

MASSIVE PSYCHIC TRAUMA

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Edited by HENRY KRYSTAL, M.D.

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This volume is dedicated in honor of the survivors of the Nazi onslaught. They are the living proof of the inviolable dignity of man, the resourcefulness of the human spirit, and inalienability of individual rights.

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HENRY KRYSTAL, M. D.

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I. Patterns of Psychological Damage

THE SCOPE OF THE PROBLEM OF MASSIVE TRAUMA

Extreme circumstances of traumatization—disasters, catastrophes, and overwhelming social situations—effect marked changes in the people subjected to them and leave them with life-long problems. The aftereffects resulting from such monstrous social and psychological experiments may be observed in certain groups. One such group has been represented by survivors of Nazi persecutions, whom we have studied in detail. This population represented an extreme in terms of the destructiveness of the impact which it received—an impact created by persecution of increasing degrees, reaching indescribable heights of degradation, starvation, terrorization, and isolation. After these and many other abuses, the group was subjected to a systematic destruction. The survivors who now live in the United States came to our attention because of the German restitution laws, which necessitated psychiatric examination of thousands of former persecutees.

However, having become acquainted with this group, we soon discovered that there were other groups subjected to massive mistreatment. While no other group has a comparable history of assault, duration of persecution, or degree of destructiveness, the comparison of various groups permits us to isolate the particularly harmful effects. Since we cannot, in any of the survivors, evaluate predispositions to emotional problems with any certainty, the large number and variety of groups permits us to make generalizations about the common patterns observable in various mistreated groups. For instance, when we discover that the survivors of as desperate a situation as the Nazi persecution show some problems identical with those experienced by the survivors of the Hiroshima disaster, we can be certain that these are the aftereffects of massive destruction. Such problems as survivor guilt, identification with death, shift of cathexes

from people to indestructible "nature" are phenomena which will be studied in some detail.

We anticipate that, in studying groups exposed to such special conditions, we may glean further insight into the process of psychological and social pathogenesis. We are interested in both the individual and group processes involved, and we will examine the harmful influences in a social sense, to see whether the survivors are more likely to form pathological families, groups, and communities.

Our ultimate aim is to learn from the extreme situations more about the handling and effect of trauma in everyday life. The applicability of our observations to everyday treatment and prevention becomes apparent in the fact that, in all cases, we find the psychic reality of the patient to determine the meaning and aftereffect of an experience. We have little correlation between measurable severity of persecution (e.g., length or kind of camp) and the severity of postpersecution pathology. To expect this simple cause and effect relationship would be to lose sight of the fact that the person has to interpret and live his experiences in terms of his psychic reality.

We are concerned with both group and individual responses to and aftereffects of extreme situations. This dual approach seems to be necessitated by the nature of the therapeutic problem. Individuals in these groups have certain problems which appear to respond better to a direct approach in terms of social function, the dynamics of which might be observed in a group situation. Group therapy may be of special value in handling the aftereffects of social mistreatment. This area, however, still remains to be explored.

We shall concern ourselves with the problem of individual responses to extreme mental traumatization, as well as the social pathology which is injurious to groups and individuals. For this reason, some homogeneity of our studies and contributions will have to be sacrificed, as a price for retaining a "functional double-vision," in which both aspects of the problem are in sight.

SOME TYPES OF PSYCHOLOGICAL DAMAGE NOT SUBSUMED UNDER CONCEPTS OF MENTAL TRAUMA

The aftereffects of persecutions, disasters, and oppression have produced a variety of individual and group reactions. Not all of the

psychological aftereffects, however, can be considered to be related to massive traumatization, in the psychoanalytic sense of the word.

One type of sequela which comes close to a quantitative disturbance is the "chronic reactive aggression" (Hoppe, 1962). The problem here, however, is not of a failure of mastery of an excessive stimulus, but a disturbance of affect, perhaps in some relationship to dammed-up drive energy. Since it was necessary to repress the aggression during the persecution, the individuals act as though they had to deal with an inordinate amount of aggression subsequent to their liberation. At the same time, the destructive experience which they witnessed, and the death of their families and communities, make it impossible for them to gain any security vis-à-vis the destructive powers of their wishes.

This problem is handled in many ways, producing a variety of syndromes. A very common one is the suppression of all affect, a functional "affect lameness." The turning of the aggression against the self potentiates the tendency to depression already caused by survivor guilt. Other common patterns are: somatization, loss of ability to enjoy life, and a general blocking of all affects, all of which assume a wider field of dysfunction than has been hitherto described.

We have observed widely prevalent characterological changes, the most common of which are the masochistic ones. However, some are more specifically related to the nature of the mistreatment: for instance, a concentration-camp survivor may, for the rest of his life, assume a passive-aggressive personality. Many of the male survivors tend to be permanently inhibited in their ability for sexual initiative and potency, in a manner reminding us of the ethological concept of the "defeated" male. In this characterological change, there is an acceptance of the castrated slave role.

The acceptance of the slave role may become a permanent characteristic of the survivors, some of whom act as though they have never been liberated. In a few cases, we found a severe inhibition of intellectual function, memory, and interest in anything outside of work and home routines. There was no organic brain syndrome, no mental deficiency, but rather a complete compliance with the picture of the slave laborer permitted to live only if he worked and blindly followed orders, without manifesting any interest or action of his own. The Nazis had attempted to reduce the prisoner to a sort of cattlelike creature, and unfortunately, the overcompliance of

some, especially those in their adolescence, while permitting their survival, tended to fixate them in their slave personality.

A variation of this pattern is the "house-boy slave" personality. The people in this group had a special gift for becoming personally useful to the SS men, mostly in the role of tradesmen but in other ways as well. For some, this kind of interaction had become so entrenched a way of life that even after liberation and emigration they require a "friendly enemy," whom they can appease and who, in turn, gives them "protection" against their fears. In one case, a specially skilled locksmith had so endeared himself to the Gestapo that they saved him from a "Cripo" (Criminal Police) execution. He has now established a similar ambivalent pattern, not only with his boss but with his German wife.

The problems of characterological changes resulting from homosexual abuse are especially difficult to trace back, but our studies indicate that homosexuality after liberation is not a common problem. The few male survivors who admit homosexual assaults by guards or Capos show severe problems of guilt and shame, and severe social withdrawal bordering on schizoid isolation. Problems of identification with the aggressor are ubiquitous and will be studied in some detail in this volume.

Another variety of personality change is that of a compensator for an "unfinished problem." These are people who might be described as having a "Lord Jim" problem because, like Conrad's character, they have to keep proving something—that is, they have a perpetual need to atone for cowardice or other "failures." There is either real personal shame or assumption of collective shame for the failure of the Jews to fight the Nazis. However, other reaction formations may similarly become dominant, such as honesty, cleanliness, etc. These might be considered aftereffects of the overwhelming taboos by order of the aggressors and the situations they created, or to "counteract" the Nazi stereotypes of the "inferior races."

Changes such as these may affect entire groups or societies, as is illustrated in the Exodus story about the generation of ex-slaves who had to perish in the desert. This social phenomenon was not considered in the American Emancipation Proclamation, but in our own age we are witnessing the liberation of the American Negro—not from servitude but from its aftereffects which lasted for a century.

When an entire population is reduced to an inferior status such

as that which occurs in a ghetto, a caste, or a nation (e.g., the American Indian), the individual's self-respect is damaged in ways not repairable by himself. The capacity for self-improvement is greatly limited by the restrictions resulting from total confinement to a group considered inferior by all concerned. Self-hatred is a specific symptom of social pathology in depressed communities, and is a combined individual and group problem.

In such communities, there are selective damages to certain natural forms of strivings and activities. The masculine and aggressive strivings are suppressed, and men are unable to assert themselves either in their communities or families. Under these circumstances, women tend to assume leadership in the families, while at the same time, because of their ability to submit sexually to the oppressor group, their survival is less endangered.

Hillberg (1962), in trying to understand the Jewish reaction of overcompliance to their Nazi enemies, has suggested that 1500 years of ghetto existence and persecution by the Christian Church-State had modified the reaction to threatened genocide to the extent that resistance and revenge became impossible, and only appeasement, overcompliance and evasion were available as modes of action. We have many historical demonstrations, including the German and Japanese behavior after their surrender, which indicate that certain historical, prehistorical and even ethological patterns are assumed by a conquered people, patterns which in extreme cases may include the surrender of individuals, or even nations, to extermination. Perhaps this fact has been too obvious for us to notice, but its action is implied in the expectation that one could, let us say, pass a death sentence and have the condemned individual fully participate in his own execution. Involved here is a process of suggestion in which the individual becomes convinced that he *deserves* to be killed and/or that any resistance is pointless. Should the execution be called off at the last minute, we may discover the prisoner to be psychologically damaged by the process of the formal trial or social condemnation. He may, for instance, present a picture of a "break in the life-line" and "collapse of the personality," as observed in concentration camp survivors (Venzlaff, 1963).

This is a syndrome in which the individual has lost his ability to enjoy life, to trust in others, or to display any initiative.

Related to this problem is the imprinting of the self-representation

of the victim with the projected image attributed to him and his group prototype by the aggressor group. This is another form of extreme compliance, which, in the case of the survivors of Nazi persecution, was accomplished in a relatively short time, leaving permanent aftereffects subsequent to the removal of the mass-suggestion. Some survivors still consider themselves inferior, worthless, "dumb," and bearers of disease. Every characteristic attributed to a group by the majority will be picked up and acted out by certain individuals within the group, not without some apparent or temporary advantages. The well-known examples of this are: the edicts of the Middle Ages prohibiting Christians from engaging in money lending; the prohibitions which denied Jews entrance into the trades, professions or land ownership. When the Jews changed their occupations as a means of compliance, they naturally became the object of projection of repressed impulses by the Christians, with the effect that the "devil" theory of Jews was spawned and usury was regarded as a Jewish vice. We are dealing with the exact problem in relationship to sex and prostitution in the United States. The general prudish and puritanical attitude attributes the role of prostitute to the Negro woman, a role with which a few Negro women may be forced to comply. It is quite apparent that such destructive forces are operational not only in societies composed of two or more groups, but even in homogeneous groups or families, where an individual will assume an undesirable role unconsciously attributed to him by his parents, family, peers, or society. Thus, again we are returned from the extremes to the psychopathology of everyday life.

However, in the course of a normal society and life, certain aids are available for maintaining normal function, among which religion is probably the most important single factor. The common contents of religion are the faith in the essential benevolence and justice of God, and his beneficence to the good and faithful. Such beliefs, however, cannot withstand so massive an aggressive assault as was the destruction of European Jewry. Under such circumstances, the normal function of religion fails for many survivors. The tendency to substitute and multiply rituals is also the aftereffect of the loss of faith in God and loss of confidence in the benevolence of man. The disturbance in object-relations, which borders on the schizoid, inevitably includes a disturbance in affect expression and communication. In contrast to schizoid personalities, these individuals yearn

for the return of their former ability to express affection and to be spontaneous. Yet, despite their wishes, when in the presence of their close ones they “freeze up”; the degree of anxiety and tenseness which they experience prevents them from communicating anything except demands or anger. Under these circumstances, all social intercourse becomes hard work and physiologically stressful. Only formal, structuralized relationships are possible, and these are typically affect-lame and sadomasochistic. The aftereffects of certain special situations such as “missed adolescence,” identification with death and with the dead, loss of one’s children, and rape will be discussed in detail.

At this point, however, one additional observation seems to be in order: namely, that the phenomenon we are observing is a select group of people who were able to adapt to extreme man-made situations and survive them. We do not know to what extent some characteristics of the group are due to selection. We wonder, for instance, whether their great tendency to peptic ulcer and arthritis is in some way related to a specific type of response to stress which ultimately made them able to respond to emergencies in life-saving circumstances. Even the successful adaptation may, and in fact is very likely to continue to present a pathogenic force within the psyche. Interestingly, the very success of an adaptation may favor its rigid persistence under circumstances where it is no longer necessary or adaptive. People continue to live in “portable ghettos”¹ and concentration camps.

It is hoped that the study of these aftereffects and problems may help us to understand, treat, and prevent traumatization in the milieu where it occurs most commonly: the home.

¹ Emanuel Tanay, M.D., personal communication.

II. The Problem of the Survivor

THE PSYCHIATRIC EVALUATION OF EMOTIONAL DISORDERS IN SURVIVORS OF NAZI PERSECUTION

WILLIAM G. NIEDERLAND, M.D.:

This paper will consider, from a psychiatric and psychodynamic point of view, some of the medical, mental, and social problems encountered among the survivors of former German concentration camps and other forms of persecution (years of hiding, of physical and mental uprooting, emotional and intellectual erosion, etc.). Those of us who are engaged in rehabilitation work with these survivors have noted an increase in the intensity and frequency of such problems. As early as 1948, Paul Friedman, one of the first psychiatrists to survey the postconcentration-camp scene in Europe, spoke out against the fallacious, if widely held belief that the suffering endured in Nazi concentration camps ceased at the cutting of the barbed wire. He commented on our "astonishing oversight" in overlooking the psychological plight of these victims and stated:

It seems altogether incredible today that when the first plans for the rehabilitation of Europe's surviving Jews were outlined, the psychiatric aspect of the problem was overlooked entirely. Everyone engaged in directing the relief work thought solely in terms of material assistance. . . . We accepted the theory that the very fact of survival was evidence of physical and psychological superiority—without looking too closely at the implications of this statement, which dishonored millions of martyred dead [p. 601].

Presented at the Fifth World Assembly of the Israel Medical Association, Jerusalem, August 16, 1965. Originally published in the *Journal of the Hillside Hospital*, 10:233-247, 1961.

As far as the situation in the U.S.A. is concerned, Friedman's statement merits qualification. Since the arrival of the first survivors of Nazi extermination camps in this country, approximately 20 years have elapsed, during which it was my privilege to serve on the psychiatric staffs of various American institutions, including hospitals, the United Service for New Americans (later named New York Association for New Americans), and now as chief consulting psychiatrist to the Altro Health and Rehabilitation Services in New York. These are all agencies or institutions with long-established programs for the care, therapy, rehabilitation, relief, and guidance of such victims. In fact, it is material derived from these psychiatric experiences and firsthand observations which forms the basis for this report. Though it is almost impossible for the outside to comprehend fully the degree of stark inhumanity and ferocious savagery which most concentration-camp survivors had to endure, we must try—in our efforts to alleviate their sufferings more effectively—to arrive at a better understanding of the dynamics involved here and to penetrate, cautiously and if at all possible, into some of the psychological processes that affect them. For some of the most severely traumatized victims, the therapeutic task may well prove insuperable.

With the introduction of the West German indemnification laws a few years ago, new problems of great medical and social import have arisen concerning especially the psychiatric-forensic evaluation of mental disturbances or symptoms in survivors of Nazi persecution. Since generally speaking, according to existing legislation, the causal connection or at least the probability of such a connection between present illness and the damages in body and/or mind suffered through the persecution must be legally established, medical testimony is frequently required to demonstrate that the victim's ill health is *verfolgungsbedingt*, i.e., caused by or connected with the calamities and afflictions experienced by him through Nazi persecution.

Here major difficulties often begin, particularly in the case of psychiatric disorders. Some so-called expert opinions fail to allow a *verfolgungsbedingte* connection outright and ignore the victim's disastrous experiences in Nazi Germany almost completely, with negative consequences not only to our insight but also to the claimant whose legitimate demands for compensation are bluntly rejected. Two brief examples, taken at random from recent observations in

such cases, will illustrate the refusal technique employed by some of the West German indemnification offices (*Entschädigungsämter*). In one case the victims's claim for compensation was denied with the following statement:

The claimant was nineteen years of age when he was first exposed to the procedures of Nazi persecution. It cannot be assumed that their psychic working through in a person of that age can give rise to lasting anxiety symptoms or other psychological manifestations. It must therefore be denied that there are any disturbances in the claimant attributable to the emotional experiences connected with the persecution.

With this type of reply the claim was summarily rejected.¹ The decision of the *Entschädigungsamt* contained hardly any mention of the fact that the victim had spent almost six years in various concentration camps, had been brutally maltreated through all that time, and had lost his parents and most of his other family members through extermination by the Nazis, as a result of which a sister and he were the only survivors of a Jewish family numbering close to 80 or more members. Nor did the German Compensation Board give consideration to the fact that the claimant's chronic reactive depression, his complete helplessness and restlessness, his reduced ability to work, walk and speak, might have resulted from the several cerebral concussions he had suffered when he was beaten in the concentration camps.

In the second case, the rejection of a legitimate compensation claim was even harsher. In the "expert" opinion of the German University Psychiatric Clinic in M., the affirmative testimony of two New York specialists was overruled with the following laconic statement:

There is a great deal of evidence that there exists a psychic maldevelopment in Mr. H. . . . We see, however, no possibility of assuming a causal connection or possibility of such a connection between this maldevelopment and the persecution undergone by him until 1945.

The claimant was under 14 years of age when he had been brutally separated from his closely knit, and until then harmoniously functioning

¹ On the basis of my psychiatric testimony to a Higher West German Compensation Court, this decision by the Lower *Entschädigungsamt* was later overruled and the patient was adequately compensated.

family, by the arrival of the Nazis in Poland in 1939. All his life he had felt extremely close to two of his sisters who at the time of the German invasion had fled to another part of Poland. In order to join them, driven by his loneliness and longing for them, he went back secretly to see them and found them, but was soon caught by the Nazis again, who cruelly beat him daily for two months. Then they sent him back to the work camps in K. and later in T., while his parents and two sisters were shipped to concentration camps and killed. A brother was killed in another concentration camp. The youngster was sent from the work camps to various notorious extermination places such as Auschwitz and Mau-thausen where he underwent frequent beatings, starvation, and other forms of maltreatment. At liberation he weighed 70 lbs.; he then spent many months in D.P. hospitals in Europe. Since his arrival in the U.S.A. several years ago, he has never had—to use his own words—“any peace of mind, any rest, never can keep a job for more than a short time, and cannot adjust to anything.” He always lives in fear, still regards himself as an outcast, feels he is in constant danger of being persecuted again. He looks and behaves like a hunted animal. He also suffers from outbursts of uncontrolled rage alternating with periods of complete apathy and depression, has frequent nightmares which are filled with horrifying pictures about his concentration-camp experiences—scenes of killing, heaps of corpses surrounding him, or situations in which he is running for his life while being chased by uniformed Nazis.

The case is now up for appeal. In my psychiatric testimony I take sharp issue with the above-quoted denial of the victim's claims by the University Clinic in M., and point to the unabated persistence of psychiatric persecution sequelae in the patient.

In view of such negative attitudes on the part of so-called experts (who, it must be added, are not always German physicians) it appears essential to familiarize ourselves at least phenomenologically with those psychiatric disorders which can be found with some regularity in a number of surviving victims. An attempt at clarification is all the more indicated, since much psychiatric testimony is wasted or sometimes used against the legitimate compensation claims of the victim, because it trails off in an abstract discussion of forensically irrelevant comments such as *Anlage*, constitutional components, infantile sexuality or the like, instead of concentrating on the severely traumatizing experiences suffered by the claimant during the years of persecution. As important as early developmental factors for the pathogenetic manifestations of neurotic and psychotic conditions are,

they can never be the sole consideration in the psychiatric evaluation of mental disorders in concentration-camp survivors. Even reports from competent specialists or reputable psychiatric institutions sometimes contain only a sentence or two on the persecution experiences of such patients, but they hardly ever fail to describe in detail certain features of their sexual behavior, family difficulties, and other problems.

Among the more common psychiatric conditions encountered in survivors, I wish to mention the following:

1. A frequent clinical picture, or rather a psychological "imprint," common to many of them. Though difficult to describe in precise terms, it has been recognized independently by observers in many countries and has been variously named "postconcentration-camp syndrome" (Rosenman, 1956), "chronic reactive depression" (von Baeyer, 1958), "depression due to uprooting" and the like. It is characterized by a pervasive depressive mood with morose behavior and a tendency to withdrawal, general apathy alternating with occasional short-lived angry outbursts, feelings of helplessness and insecurity, lack of initiative and interest, prevalence of self-deprecatory attitudes and expressions. In extreme cases, there is something of a "living corpse" appearance or quality in these victims, not too surprising a circumstance if one considers that most of them lived for years among actual corpses and dying persons in the extermination camps, that they were in a sense themselves walking or prospective corpses, and in part owe their survival to some extraordinary ability to live the existence of a "walking corpse" while their fellow inmates succumbed.

2. A severe and persevering guilt complex, the far-reaching pathological significance of which will be discussed below.

3. A partial or full somatization, ranging from rheumatic or neuralgic pains and aches in various body areas (headaches, tremor) to well-known psychosomatic disease entities (peptic ulcer, colitis, respiratory and cardiovascular syndromes), usually accompanied by hypochondriacal symptoms.

4. States of anxiety and agitation resulting in insomnia, nightmares, motor unrest, inner tension, tremulousness, fear of renewed persecution, often culminating in paranoid ideation and reactions. Such survivors appear chronically apprehensive and perpetually

harassed, are often afraid to be alone, though unwilling to engage in social activities or even conversation.

5. Personality changes showing a more or less radical disruption of the entire maturational development, behavior and outlook, especially in patients who were taken into concentration camps in early life, but not entirely lacking in adults subjected to the stress of prolonged persecution.

6. Fully developed psychotic or psychoticlike disturbances with delusional or semidelusional symptomatology, paranoid formations, morbid brooding, complete inertia, stuporous or agitated behavior. Here also depressive features usually dominate the clinical picture.

Mental symptoms due to organic brain damage, or cerebral concussion caused by beating on the head and other forms of maltreatment, are omitted here. Nor is the above list intended as a full classification of the psychiatric consequences of Nazi persecution. It represents a condensed, incomplete survey of some clinically and dynamically significant aspects. Often the clinical pictures overlap and the symptoms may resemble those encountered in "ordinary" mental disorders, although this does not necessarily militate against their persecution-connected genesis. The psychic apparatus, like the body, has only a limited number of reactive responses to external or internal stimuli and cannot produce entirely new systemic responses to the onslaught of even such massive traumatization as concentration-camp horror. Hence we see the multitude of somatic, depressive, obsessive, hysterical, and other symptoms in these traumatized people—symptoms which are often erroneously attributed to the *Anlage* instead of to the traumatization of such patients.

Of importance in many cases, especially from a forensic-clinical-psychiatric viewpoint, is the existence of a relatively symptom-free interval between the liberation or later discharge from D.P. hospitals in Europe and the development of new symptoms, usually after a period of months or years following their arrival in the U.S.A. Legitimate indemnification claims have been denied because of the lack of what the German compensation courts call *Brückensymptome*, that is, medical manifestations or disabilities during the above-mentioned interval. In several medicolegal opinions I have been able to demonstrate that this symptom-free interval is characteristic of the psychic sequelae of persecution, particularly among those victims who were the only or near-only survivors of their

families, and who consequently carry within themselves a double burden (Strauss, 1957; Venzlaff, 1958): first, the actual loss, terror, and grief experienced through the impact of the disaster and the extermination of their loved ones; second, the ever-present feeling of guilt, accompanied by conscious or unconscious dread of punishment, for having survived the very calamity to which these loved ones succumbed. As long as the survivors could tell themselves, during the years immediately following liberation, that some of their missing family members might still miraculously reappear, and as long as they were exposed to the many adjustment difficulties and initial hardships following their arrival in the U.S.A., they remained relatively free of symptoms and self-punishing tendencies. When in the end they were forced to recognize, despite their magical thinking and hopes, that their relatives would never return, and when they finally appeared to be settled and even adjusted to their new surroundings, at that time they would be more likely to break down with some type of postpersecution symptomatology as described above, or with other clinical manifestations.

To return to the finding of total reactive personality changes caused by overwhelming traumatization in late adolescent or adult life, the existence of such a syndrome appears at first sight to run counter to accepted psychoanalytic formulations. Since it may therefore seem difficult for us to orient our thinking with regard to such findings, it may be well to remember the extent of the quantitative factors here involved, as well as to consider that difference of scale, when it is great enough, amounts of difference of kind. I believe that we thus have to assume the emergence of a qualitative factor which, impinging on the individual's ego organization with a devastating impact, and relentlessly maintained over long periods of time, is capable of producing similar changes.

The coming of the Nazis, let us say to Poland, was an attack made by one organized nation upon another. But to the Jews living in Poland it represented more than that; it also constituted more than a threat to their physical and personal existence. To understand this, it is well to bear in mind that terror and fear are not synonymous. While the latter refers to an anticipated danger, terror relates to an experience in which the total personality is not only involved, but is actually overwhelmed or in the process of being overwhelmed. Terror is therefore an experience which is almost ineffable. The

lives of many Jews under the relentless Nazi terror can perhaps be compared to a protracted life-in-death existence. Friedman (1949), quoting Victor E. Frankel, a physician and former inmate of Auschwitz, mentions the latter's report about one of his concentration-camp experiences:

He was awakened one night by the cries of the man on the mat next to him, who was in the throes of a terrible nightmare. Frankel put out his hand to waken him—then withdrew it. He realized that whatever the nightmare, the reality to which the man would wake was far worse [p. 163].

It must be admitted that to think on this scale is difficult for us. But when the physician who is dealing with the problems of concentration-camp survivors has become aware of the scale, he will not commit the gross error of confusing frustrations growing out of daily life occurrences with the traumatization undergone by those who lived in the shadows of gas ovens. Although this may appear self-evident, it must nevertheless be mentioned here, since precisely such an argument was used by the University Clinic in M. in a certified opinion to the Compensation Board in T. opposing the restitution claims of a middle-aged schoolteacher who was suffering from peptic ulcer after her liberation from Nazi terror, a disease which the rejecting experts themselves admitted, in all likelihood had been contracted in a concentration camp. Ulcers, they stated, are not *verfolgungsbedingt*.

To return to the question of nightmares in concentration-camp survivors, they still occur with the same intensity and frequency in many cases today, 15 or 16 years after liberation. A study of their content shows that these nightmares are directly derived from or clearly connected with the harrowing experiences of the persecution years. In those patients having delusional formations during their waking hours similar findings can be elicited. The following is a brief clinical illustration of this:

Mrs. M. Z., born in Poland, was subjected to Nazi persecution from 1939 to 1945 (ghetto, forced labor, inmate of several concentration camps). Married after liberation in Europe, she arrived apparently healthy in the U.S.A., during the forties, together with her husband and two children, and settled in Brooklyn. In 1952, she suddenly fell ill with serious psy-

chotic symptoms (hallucinations, delusions, paranoid ideas) after the outbreak of a small fire in the basement of her apartment house. The fire was promptly extinguished, but the patient had to be hospitalized. Her indemnification claim was rejected by the German compensation authorities, mainly on the basis of psychiatric testimony by a New York specialist that "true mental diseases are of endogenous origin," i.e., that her disease was not due to Nazi persecution and therefore unconnected with her experiences in the ghetto and concentration camps. Rather, the testimony continued, the illness "was grounded in the *Anlage* of the personality." The decision was appealed, and in my opinion I could show that the patient's acute *breakdown occurred when she saw the smoke* of the fire coming from the basement through the window. She then wanted to throw her children out of the window in order *to rescue them from the danger of the invading smoke and fire*, personified by her delusionally as the invading Nazis. She said she could not look at fire or smoke, since *it reminded her of the death of her parents in the Auschwitz gas chambers*. She accused herself of having caused her parents' death, became hallucinatory, afraid of her dead sister, and *demand[ed] to be killed herself and bitten to death*. It thus became clear that *Anlage* or no *Anlage*, the outbreak of the disease in 1952 was definitely *verfolgungsbedingt*, that is, dynamically connected with her persecution experiences, since the full delusional content centering about smoke, gas, fire, death, killing, and being killed was directly derived from and pointed to the patient's life under Nazi rule, with most of her delusional fantasies focusing on the Auschwitz crematorium. It was here that both her parents as well as her four brothers and sisters had been put to death, while she—first in Auschwitz and then in other camps—had survived.

A closer study of the connections in this case further reveals the dynamics of what I have called "the symptom-free interval" and its relation to the ever-present guilt in the survivor. The patient came to the U.S.A. in relatively good health and remained well until 1952 when the fire occurred. (Since until then she had had no *Brückensymptome*, this chronologically later breakdown was also held against her in the above testimony.) It is precisely these late sequelae, however, erupting only after a period of years, in consequence of some precipitating external event (such as the fire in the present case), but often also without such an event, which appear to be characteristic of a considerable number of persecution cases. W. von Baeyer (1958) of the University of Heidelberg has communicated similar observations. Since, as mentioned above, guilt in these sur-

vivors is a double and almost intolerable burden, it imposes so overwhelming a load on the entire psychic organization that it can hardly ever be faced fully and is kept under repression for as long as possible. The repression is reinforced with the help of an often magically sustained expectation that some of the dead family members may still return. The hardships and unsettled living conditions through the first years after liberation, later the manifold difficulties connected with the emigration, serve further to bolster the initial repression. When finally the guilt erupts into consciousness, with or without a precipitating event, the mental distress resulting from it becomes overpowering and can involve the entire personality. Clinically this distress becomes manifest in two typical ways: (1) through a feeling of depression, inner misery, and pain; (2) through a feeling of being persecuted, attacked, and hated. Without going into a detailed analysis of the ego and superego aspects of these intricate processes, suffice it to enumerate some of the more frequent reactions to the survivor guilt which we are apt to encounter under these circumstances: massive denial and repression; brooding depression and self-absorption; expiatory and propitiatory tendencies, often masochistically tinged; multiple neurotic, psychotic, or psychosomatic symptoms or syndromes such as compromise formations; obsessive-compulsive rituals to reduce the tension caused by the guilt and perhaps also to produce "affective anesthesia," i.e., a sort of mental numbness in the face of overwhelming feelings of fear and guilt. The depressive components of the latter are primarily responsible for the long-standing apathy and lack of initiative found in so many survivors.

To return to the patient who became acutely ill when smoke and fire reminded her of the Auschwitz extermination ovens in which her family perished, there is another detail which requires our attention, namely, her request to be killed or *bitten to death*. In this one demand, I believe, the enormity of the patient's personal tragedy (and the bestiality of the Nazi persecution) become strikingly apparent. Without being able to prove it, because no physician would or perhaps should go to such exploratory depths in these tortured people without inviting catastrophe, I nevertheless venture to regard the reference to biting as an almost direct allusion to cannibalism, possibly the mode of survival which alone helped the patient to stay alive. Be that as it may, instead of going further from here,

I will limit myself to quoting from Friedman's (1949) firsthand observations: "One cannot live for years in a world in which cannibalism becomes a reality, in which one is forced at the point of a gun to eat one's own feces, without profound internal adjustments . . . without [being] reverted to a primitive, narcissistic stage of development."

There can be little doubt that the West German Republic has made a sincere effort, through its compensation laws, to indemnify Nazi victims. Yet it would be a disservice to the victims and ultimately to the cause of the indemnification legislation itself not to look into how it is carried out, especially in the field of psychiatric evaluation. A paucity of reported cases in no way militates against the prevalence of the problem. On the basis of so-called expert medical testimony, decisions are made that are contrary to well-known clinical experience. Over a period of months a group of psychodynamically oriented New York psychiatrists and psychoanalysts—among them Drs. Gustav Bychowski, K. R. Eissler, Ernst Hammerschlag, Max Schur, and the present author—have reviewed case after case in which compensation was refused on grounds so tenuous that they could hardly be distinguished from pretexts.

Cases have been reported of children who for years were kept hidden in cellars or stables which they were not permitted to leave for a single moment. Nor were they allowed to make a sound, since their families were constantly on the verge of being discovered. Dr. Eissler² reports a case in which a father was several times on the verge of killing one of his own children in order to save the others. The victims of such upbringing must necessarily show marked developmental distortions and abnormalities of various kinds. Still the thesis is maintained that when such disturbances manifest themselves, it is because of innate defects which no one has yet demonstrated to exist, but which these deplorable survivors of persecution are supposed to possess constitutionally.

Where this type of reasoning appears inapplicable, other equally questionable grounds are resorted to as a basis for belittling or denying the claim.

In a case studied by Dr. K. R. Eissler, the persecution victim was a 13-year-old schoolgirl, N. G., who was first imprisoned in a ghetto, then in

² Personal communication.

the notorious concentration camp Stutthoff. Her father was killed. During her three years of imprisonment she was brutally maltreated, starved, and finally so severely beaten over her face and jaw, that she developed an abscess over her right lower jaw, followed by an infectious fistula. The fistula required surgery after her liberation. She was left with a visible scar and with the mental distress which often results from such permanent facial damage. She is now married, has children, lives in the U.S.A., but suffers from psychiatric sequelae (feelings of unworthiness and shame, insomnia, fears that things will turn bad for her again, wants a brain operation "to forget it all," etc.) connected with the persecution. Her compensation claim for damages in body and mind received the following response from the Compensation Board "expert":

It appears credible that the scar is in a certain sense disturbing. Nevertheless, it is a fact that Mrs. G. is now married and that those surrounding her have become accustomed to this. . . .

Her claim was rejected. In its negative decision the Compensation Board hardly touched upon the psychiatric consequences of the persecution experiences, disregarding both their physical imprint (permanent facial damage) and her own feelings of humiliation and shame resulting from the disfigurement which, in Dr. Eissler's opinion, is a "lasting reminder to her of her tragic past in the concentration camp." The bias of the *Entschädigungsamt* was in this case particularly conspicuous, since an entry in the hospital ledger written by an unidentified person four years after the start of the persecution read that the patient had the fistula "for years," which was arbitrarily interpreted by the medical expert—the Compensation Board followed his reasoning—as referring to a time prior to her persecution. Her own sworn statement as well as that of witnesses to the effect that she had had no fistula prior to her imprisonment was disregarded.

Drs. Eissler and Schur³ have examined mothers whose children

³ Dr. Schur examined a Jewish mother who developed a chronic reactive depression in consequence of various persecution experiences culminating in the following event: During a raid by invading Nazis, her two-week-old baby boy was torn from her arms by an S.S. man and thrown against a wall. The mother saw her dead infant with the brain exuding from its smashed skull. She has never been able to forget the incident. Compensation for the patient's chronically depressive condition was granted for a limited time only, because—according to a specialist's testimony—"reactive depressions clear up in a few years under ordinary circumstances." In his psychiatric evaluation, Dr. Schur had to point out that, though reactive depressions may sometimes clear up in a relatively short time, this mother's depression was certainly precipitated by traumatic events far beyond what could be called "ordinary circumstances."

were killed virtually before their eyes, and who were brutally beaten when they expressed grief and despair. The serious mental disorders now affecting these mothers are not attributed to these traumatic experiences, but rather to constitutional factors, and, on the basis of an outdated psychiatry, compensation is denied them. In two survivors under my observation, both suffering from severe depressions following years of concentration-camp imprisonment, "expert" testimony asserts that their present conditions have nothing to do with their experiences, but are the result of *anlagebedingte psychoneurotische Reaktionen* (*Anlage*-produced psychoneurotic reactions). In a third case, that of a woman suffering from ulcerative colitis contracted at the height of her persecution experiences in Nazi Germany, the psychiatric expert not only diagnosed these legendary *Anlage*-produced psychoneurotic reactions as the cause of her disability, but also spoke of her flight from Nazi Germany as "a transfer to a less suitable climate" which, according to his testimony, cannot be regarded in the same way as uprooting, to wit: her being abused, terrorized, humiliated, and finally chased out of her country is here equated with some peaceful form of "transfer" to a country with another climate. In some of these opinions almost any allegedly valid causation seems to be seized upon (*Anlage*, constitution, heredity, climate, endogenous factors, obsolete notions, confusing nomenclature), as long as the connection with the Nazi persecution can be disclaimed or made to appear unlikely. It is only fair to add that this is not a universal criticism of all the psychiatric testimony adduced in these cases. In the U.S.A., Germany, and elsewhere many experts share the present writer's approach and point of view concerning the massive and the total personality-disrupting quality of the traumatizing factors involved. In recent studies by von Baeyer (1958), Venzlaff (1958), Bensheim (1960), Engel (1961), and others, the magnitude of these factors and their *Fortwirken* (continued action) *after liberation* has been recognized. Von Baeyer and Venzlaff also take issue with the common practice of comparing psychic reactions to war injuries, accidents, and air-bombing attacks, with concentration-camp experiences. Stressing the fallacy of such comparisons, the authors point to the magnitude and uniqueness of the latter, which make of them a phenomenon that has never been equalled in the history of modern civilization. With regard to the psychological effects of all this, they correctly say that the trauma of

being outlawed, outcast, and reduced to the status of unwelcome vermin (*lästiges Ungeziefer*) has to be considered in addition to the actual cruelties suffered by victims of the persecution.

After this gloomy catalogue of human suffering let me add a cautious note, not of optimism unfortunately, but as a suggestion toward more constructive efforts. While in many of the severely damaged persecution victims the prognosis *quod restitutio ad integrum* appears rather unfavorable, it is my feeling that patient and sustained rehabilitation work with them is indicated in all cases. Such efforts should include the whole array of available professional teamwork: psychotherapy, chemotherapy, social casework, family care, guidance, counseling, day-care centers—in short, *a maximum treatment plan* instead of the minimum psychiatric procedures often in use today. Of considerable value in some patients, I believe, are methodical rehabilitation efforts in sheltered workshop settings as, for instance, those provided by the Altro Health and Rehabilitation Services in New York City (Bellak and Black, 1960; Benney, 1960). Here patients who have never worked before or whose earlier work experience has been violently disrupted by illness, persecution, disabilities of various origins, are gradually trained or retrained for work in a sheltered, supportive, noncompetitive setting which is as free from anxiety-producing factors as possible, and where at the same time medical care, psychiatric help, social services, and other modern facilities are constantly available. Instead of going into theoretical considerations, I shall conclude with a practical illustration:

W. J., born in Poland in 1937, was the only child of healthy, strictly orthodox Jewish parents. When the Germans overran Poland in 1939, the family went into hiding and lived for a while in a forest. Later they were hidden by a Gentile family in a cellar for 26 months (1943 to 1945). The cellar was entirely dark and so low that there was no standing room for the adults. They received some food only every three days. When the child cried in hunger, the mother had to stifle him bodily so that his screaming would not reveal their hideout. The boy was less than six years old when he entered the cellar and emerged when he was about eight. At liberation, his physical and mental growth corresponded, in the view of the parents, to that of a three- or four-year-old. The family arrived in the U.S.A. in 1952 where after some time the youngster, then 16, began to become suspicious and unruly in school. He felt ridiculed by teachers

and students, refused to leave his house, thought that people in the school and street were against him. He was hospitalized in a mental hospital with the diagnosis of primary behavior disorder, paranoid type. After discharge from the hospital in 1954 he was referred for rehabilitation to the Altro workshops where, for a period of 22 months, he was helped to resocialize and was trained in the clerical program for office work. Initially this proved difficult because of the persistence of his paranoid thinking (he usually spoke of other people as his "enemies"), isolation from others (isolation in the cellar had saved his life), distrust of everyone, brooding preoccupation with himself interrupted by violent outbursts of rage, as well as general physical and mental underdevelopment. He was aware, however, to some extent, of the pathological nature of his thinking. After prolonged rehabilitation efforts, with continued psychiatric casework, family counseling, and constant guidance, he was able to accept minor jobs in private employment such as messenger work in industrial companies, and to get along reasonably well with fellow workers and foremen. Today, at 24 years of age, he may be regarded as partially rehabilitated, but still requires frequent counseling and help from the agency. Full recovery, if attainable at all, will in all likelihood necessitate more years of painstaking rehabilitation effort and systematic care on all levels.

The moderately favorable outcome of our work in this case indicates the urgent need not merely for appropriate psychiatric evaluation of persecution victims, but also for expansion of the rehabilitation and restitution services, as yet all too scantily available to them.

III. Studies of Concentration-Camp Survivors

In the past the concept of traumatic neurosis was related to the consequences of the overwhelming of the individual's protection against stimuli by massive unmastered excitation (Freud, 1955b; Fenichel, 1945), and it was hence considered in this light. The experiences in long-term follow-up on severely traumatized persons during the last 20 years indicate a need to reconsider every aspect of the nature and sequelae of massive psychic traumatization.

Trauma is defined in terms of the psychic reality of the individual involved in it; it is brought about by the overwhelming of the stimulus barrier and the resulting dynamic disarrangement rather than by any external situations (Fenichel, 1945). There are certain situations, however, which by their nature, structure, and duration can be, for practical purposes, assumed potentially traumatic to any person exposed to them. Freud (1936) suggested that one such situation is a realistic danger of destruction which would mobilize fear of death and castration anxiety. He stated that in such danger the "ego reacts as a state of being forsaken or deserted by the protecting superego, by the powers of destiny—which puts an end to security against every danger."

We believe that the concentration-camp and death-camp experience was potentially traumatic in each of the possible ways named by Fenichel (1945), such as: (1) the overwhelming of the ego with stimuli; (2) the enforcing of regression and passivity associated with an enforced blocking of ego functions; (3) the necessitation of mastery by repetition (which however, in these particular cases, had to be postponed for many years in the service of survival); (4) the upsetting of "the entire economy of mental energy . . . and of the equilibrium between repressed impulses and repressing forces."

In further following the thoughts of Fenichel, one discovers that the concentration-camp experience was especially prone to

producing psychoneurotic complications instead of "traumatic neuroses" for many reasons. Particularly significant in this distinction was the fact that it had to be dealt with as a "screen function" (Glover, 1929) linked to previous traumata because of the sado-masochistic nature of the experience, which overwhelmed the individual with the apparent fulfillment of every sadistic and masochistic impulse imaginable. Kardiner (1941), whose work described the experiences with traumatic neuroses in World War II, has described the following constant features of this syndrome:

- 1) A fixation on the trauma altering the conception of oneself and outer world.
- 2) Typical dream life.
- 3) A contraction of the general level of functioning.
- 4) Increased irritability.
- 5) Proclivity to aggressive action.

In relation to the massively traumatized individuals, we add, upon J. A. A. Meerloo's suggestion, the following reactions:

- 6) Relative retrograde amnesia (life begins with trauma).
- 7) Regressive behavior.
- 8) Compulsive repetition of trauma in dream life.
- 9) Massive somatization.

Traumatic neurosis was regarded as a short-term, self-limited syndrome. Since most psychiatrists accepted this concept, they were hard put to believe, when told by a veteran of World War II, that 15-17 years after the traumatic event the patient still had anxiety dreams relating to the traumatic incident. Either the textbook or the patient had to be lying. Distinct symptomatology of the traumatic neurosis was no longer in evidence, and yet the veterans complained of a variety of diffuse and vague symptoms. These symptoms however were present in psychic areas related to somatic function. A 15-year follow-up of shell-shocked American soldiers showed a persistence of "startle reactions, sleep disturbances, dizziness, blackouts, avoidance of activities similar to combat experience, and internalization of feelings" (Archibald, 1962). Seventy per cent of the veterans suffered from headaches, and most had a variety of fears. The old concept of the syndrome of traumatic neurosis was *defined* by its immediate onset after the trauma. The new facts overruled this definition—even as late as five years after the war, Veterans

Administration Clinics were finding "fresh cases that have never sought treatment until the present time" (Futterman and Pumpian-Mindlin, 1951).

Thus certain shibboleths had to give way to more current observations. Now, other preconceived notions similarly have to be questioned, as for example, the idea that in order to establish a causal relation between a present emotional problem and a past trauma it is necessary to prove a continuation of symptoms without interruption. This notion has been challenged by the evidence that in many individuals there appears to be a "symptom-free interval," and by observations which suggest the possibility of absorption of the symptoms by masochistic character traits or somatizations which do not become conspicuous for a long time.

The observations related to the sequelae of massive psychic trauma emphasize the need to view the emotional adjustment of an adult as still being in a state of flux and subject to maturation and development no less than regression. Traumatic situations set up pathogenic influences which, in connection with infantile conflicts, may generate anxiety, regression and symptom formation. Under certain emergency situations, however, the traumatic neurosis may not become apparent until some time later, when the individual confronts himself belatedly with frightening or guilt-provoking perceptions, experiences or acts, which remain repressed for the duration of the emergency. This reporter is indebted to Dr. Channing T. Lipson for pointing out that we have no knowledge of the nature of perception of experiences which are dealt with by immediate denial, repression or isolation. Repression causes a splitting of the ego, with setting up of counter-cathexis against the return of the repressed. The psychic contents of such experiences have, in analytic work, been observed to become subject to the primary process cognition and especially condensation and fusion with screen memories of previous traumata (E. Glover, 1929). The experiences with concentration-camp survivors suggest that the affects related to these perceptions are likely to become somatized, and observable only as anxiety or depression equivalents.

This degree of somatization has been anticipated by Greenacre (1952) as a result of observation of trauma in early infancy. Anna Freud (1967) pointed out that in a child, the very evidence of traumatization is demonstrated in the spilling-over of the reaction

into "physical responses via the vegetative nervous system taking place of psychical reactions" (p. 292). Our observations are that while youthful survivors tend to somatization of their anxiety and repression of the verbalized emotional responses to the trauma, age is not the only criterion, nor even maturity. Ordinarily, with single traumatization the symptomatology of the traumatic state and its late sequelae depends upon the magnitude and nature of the traumatic perceptions, the degree to which the stimulus barrier is overwhelmed, the helplessness, the disorganization which follows, and the nature of conflicts revived and repressed ideas which have broken through. Under these circumstances, the resources, defenses and investment of the ego, the degree of availability of verbalization (i.e., desomatization—Schur, 1955) would constitute a barrier against the somatization of affect. However, in massive psychic trauma, with situations such as the survivors of Nazi persecutions, who right after the destruction of their families, communities, after uprooting, were thrown into the constantly life-endangering, degrading, and regression-fostering situation of the concentration camps, we find that the childhood susceptibility to trauma returns and the affective responses become resomatized (deverbalized). In addition, in many survivors, their psychological reactions to the destruction and oppression have been handled by widespread repression, with a need to substitute "physical" symptoms for the "missing" psychological contents of their reactions.

As a result, we observe a variety of psychosomatic disorders, most related to the expression of affect via hyperactivity of the autonomic nervous system or muscle tension. Similarly, there are relatively common conversion reactions dramatizing death and rebirth, or acting out of other specific phantasies. All of psychoanalytic writing and especially that of Freud is replete with clinical evidence of the pathogenicity of psychic trauma. Freud's original insight that hysteria was an attempt of mastery of memories by repetition (1893, 1895) was later extended to assign a permanently important role to traumatization in the genesis of emotional problems. The stimulus of the experiences with the "war neuroses" led Freud (1919) to say, "We have a perfect right to describe repression, which lies at the basis of every neurosis, as a reaction to a trauma—as an elementary traumatic neurosis" (p. 210).

Through the years, psychiatrists and psychoanalysts have demon-

strated the etiological role of trauma in virtually every nosological entity. Freud stated that neurosis in general had at the core a traumatic cause (1939). Trauma as a cause has been described in: agoraphobia, Freud (1917) and Weiss (1935); phobia and depression, Greenson (1959); obsessive-compulsive neurosis, Freud (1917) and Pious (1950); and other neuroses, Robbins (1942). Osnato (1929) related a variety of psychiatric syndromes to trauma. Hayman (1951) showed the role of early traumatization in borderline disturbances. Abraham (1907) related traumata to "dementia praecox," and Brill (1941) and Beckett (1956) to schizophrenia. Even epilepsy and hystero-epilepsy were shown related to trauma—Freud (1928), Dreyfus (1949).

Various authors found it possible to prove that specific symptoms or defenses were necessary means of dealing with traumatization such as: repetitive dream formation, Freud (1917, 1918), Wisdom (1949), Grinberg (1953), Garma (1946); memory distortions, Freud (1931); amnesia and fetishism, Freud (1927), Greenacre (1953); fixations, compulsions to repeat, inhibitions and permanent character changes, Freud (1939); denial, Linn (1952); derealization, Rosen (1955). Without a doubt, reports of more kinds of post-traumatic symptoms could be found if the search was continued.

The role of trauma in character formation has been confirmed repeatedly by: Kelman (1945), Lampl-de Groot (1963), and Greenacre (1967). Solnit and Kris (1967) consider traumatization in childhood, "as a necessary and fascinating pathway to many genetic sources of neurotic development and certain types of character formation" (p. 213).

What is disturbing, but really should not be surprising in the study of massively traumatized individuals, is that they show not one, but many symptoms and many kinds of disturbances. With most of them disturbances of a neurotic depressive, psychosomatic, psychotic-like nature occur at the same time and disturbances of cognition, memory and affectivity of "atypical" kinds overlie all of these. This makes it very difficult to evaluate and diagnose such patients on the part of psychiatrists devoted to making a single diagnosis in each case.

In addition, survivors of massively destructive catastrophe or genocidal attack present problems never studied before. The loss of a love object in childhood can be traumatic; the loss of the entire

family by a massacre and the loss of community witnessed by a child, who is then immediately confined in a dark, filthy hole in the ground for a couple of years attended by constant danger, presents a different dimension of trauma with different consequences. In order to understand and deal with such populations new concepts were necessary, such as identification with death and the dead (Lifton, this volume, chapter VII); the pathogenic effects of guilt, especially "survivor guilt" (Niederland, this volume, chapter II). In this respect, survivors of genocidal assault or natural catastrophes are in a class by themselves. The fact of aggression turned against the self, introjected and somatized, is harder to establish except in psychoanalytic or "uncovering" psychotherapeutic treatment, in which one finds that during persecutions simultaneous regression to magical thinking made the aggression too dangerous to deal with. This danger resulted in a repression of aggressive impulses toward the formerly omnipotently experienced love objects. Under these circumstances mourning of them was impossible, and this necessitated a psychic splitting with reaction formations and denial as a prominent ego defense.

The above observations are at variance with some earlier views. It seems, however, that we are dealing here with traumatization of a type and intensity never before encountered in a way available for study with modern psychiatric and psychoanalytic methods. It appears here that these very abnormal conditions have so modified the clinical picture that the nosological classifications derived from other patients (by and large from the pre-World War I patients, products of the longest and most secure peace period in the history of Europe) were inapplicable to the severely traumatized individuals. Traditional nosological classification leads to inaccurate inferences as to the degree of impairment of function and, most importantly, misdirects prognosis. For instance, the work of Kraepelin was largely devoted to correlating certain clinical pictures with a predictable prognosis. His patients developed their illnesses in a stable unchangeable milieu and with a constant pressure from the environment. Severely traumatized individuals, however, developed the precursors of their emotional problems under very different circumstances, when their environment was overwhelmingly destructive to their homeostasis, and realistically endangered their survival for long periods of time.

Is it possible that under these differing circumstances, similar clinical syndromes represent entirely different dynamic and prognostic entities? Can we make some generalizations about the psychiatric emergencies created by most abnormal situations in a way that might be helpful in therapy and prophylaxis?

Because of these weighty and difficult problems, we have found it necessary to meet periodically to consider the sequelae of massive psychic trauma. This first conference has been devoted to the problems of the dynamics of the reactions of victims of Nazi persecutions, especially those who were imprisoned in the concentration camps.

The panel participating in the Workshop consisted of: Dr. William G. Niederland, Dr. Kenneth E. Pitts, Dr. Marvin Hyman, Dr. William H. Grier, Dr. Emanuel Tanay, and myself. The group participating was composed of psychiatrists, social workers, lawyers concerned with these problems, as well as trainees in the fields of psychology, psychiatry, and social work.

The panel approached the consideration of concentration-camp survivors with an anticipation of the necessity for and difficulty in viewing all the persons involved—the aggressors as well as the victims—with charity as well as consciousness of one's need to deal subjectively with these most disturbing data. To approach the subject hygienically, it is necessary to be conscious of the pain and pathogenic forces generated in trying to live the dual experiences of being both the "victim" and "perpetrator" of genocide. In the experience of the panel, this reporter, and other students of the problem,¹ it became apparent that despite the painful affects generated, it is necessary to identify with the "aggressor" no less than the "survivor" or "martyr," in order to avoid indulging in name-calling or fault-finding. The subject at hand is especially disturbing, and therefore requires a conscious attention to the nature of one's emotional responses. While Nazis and other sadistic individuals may generate an impulse for aggressive retaliation, the concentration-camp survivors, too, provoke a variety of emotional responses, such as guilt and anxiety or disgust, because of the threat implied to our denial of death or cowardice. As masochistic characters having a need to identify the examiner with the "Nazi" of their past, concentration-camp survivors sometimes provoke intense frustration and anger in

¹ J. M. Dorsey, M.D., personal communication.

the examiner. Thus we found it both necessary and difficult to approach the concentration-camp survivor, S.S. man, Capo, or Nazi-collaborator with a conscious recognition of our own created mental representation of them.

For the students of these problems, the alternative would have been to live these experiences in a repressed way, in which the lack of conscious recognition of the identity of one's mental material would have been prompted by an urge to avoid the pain of recognition of such impulses in us.

THE CONCENTRATION-CAMP PSYCHOPATHOLOGY

The workshop was opened by Dr. Niederland, who discussed the concentration-camp psychopathology and its psychiatric aftereffects. Dr. Niederland reviewed the clinical observations on concentration-camp survivors and pointed out that the symptoms observed were those of chronic states of tension, vigilance, irritability, depression, and anxiety accompanied by sleep disturbances, anxiety dreams, and nightmares. Many concentration-camp survivors complained of headaches, fatigue, dizziness, general nervousness, diffuse anxiety symptoms, and excessive sweating. There was a wide variation of clinical pictures, from "tendencies" to withdrawal to severe disruptions of ego functions. He presented a case history in which the patient, after a symptom-free period, developed an acute psychotic break while in the army. The patient showed some characteristic symptoms, namely, a "fear of renewed persecution"² and a "mental confusion as to the past and present." For instance, on the anniversary of the day on which the patient had seen a fellow concentration-camp inmate hanged, he had become uncertain as to where he was and unsure that he was not still in Auschwitz in danger of further persecutions—despite the fact that he was in the uniform of an American soldier. Among the very typical symptoms for concentration-camp survivors which this patient displayed was a hypermnnesia for certain events, along with memory defects regarding other events

² This is accompanied by a fixation upon the traumatic events as *the* important event in their lives, and a combination of pride, shame, horror and other feelings about it. These unresolved feelings bolster the unconscious wish to repeat the experience (Meerloo, private communication).

of the period of persecution. Because of the above findings, and because of massive distortions caused by continuing guilt and denial, the reconstruction of the persecution period is a slow, laborious, and painful procedure for both patient and examiner.

It must be remembered that most Jewish concentration-camp prisoners had already been subjected to a gradual isolation, starvation, and degradation during the years preceding their incarceration. But in order to study the nature of the pathological influences of the concentration-camp experience, Dr. Niederland reviewed the concentration-camp situation. As a massive destruction machine, the abuses were systematically destroying the integrity and homeostasis of their victims. Besides the witnessing of continuous murder of fellow Jews, the prisoners were subjected to continuous anxiety, humiliation, and assault, which could be understood in terms of the effects on specific systems of mental apparatus.

THE ASSAULT ON THE EGO

The assault on the ego consisted of a systematic obstruction of its function. Among the procedures used to accomplish this aim were the "admission ceremony" (a sadistic orgy); the treatment of the prisoners as commodities (e.g., by referring to them as so many "stueck" or pieces in "Appells"); turning women into "field bodies" and tattooing the words "field body" or "field whore" on their chests (Ka-Tzetnik, 1955), i.e., prostitutes for German soldiers on the Eastern front; the deprivation of food and elementary hygienic facilities; and ultimately, the destruction of all who weakened. The Nazi brutality was systematically changing the self-representation of the prisoners from self-respecting individuals to commodities handled with less care or respect than would be accorded to cattle.

The prisoners usually went through an *initial shock* reaction which often included *depersonalization* and a dazed state in which many perished. Those who survived did so on the basis of an automatization of functions dedicated solely to the task of survival; this was accomplished by massive suppression of self-evaluation, judgment, and self-reflective powers. The suspension of superego function is also an unconscious imitation of the persecutors. The automatization or "robotization" (Meerloo, 1963a) served not only

to conserve energy, but also to ward off a severe depression which would otherwise follow the loss of all love objects or ego supports, uprooting, and degradation. As a further protection, "robotization" enabled the religious to avoid confrontation with their angry feelings at God for allowing such cruelty.

The concentration-camp S.S. empire fostered psychopathology by confronting the individuals with a massive sadistic assault, to which the prisoner could only submit masochistically. In rarer cases, Capos or other "prisoner-officials" handled the assault by becoming as sadistic as the S.S. through a process of identification with the aggressor. The deprivation of conscious individuality (including all personal possessions as well as one's name) and the absence of evident causality in the concentration camps were directly destructive to such integrative and organized ego functions as logical thinking. Since there was often no rhyme or reason for killings, assaults, or the selection of prisoners for death, this insecurity often resulted in complete panic states, and sometimes in self-destructive acts. Many of the selections were based on the killing of those individuals who had lost their value as a working utility; thus, the prisoner's body image frequently became hypercathected, resulting in a hypochondriacal preoccupation with body function which was augmented by the constant stimulus of starvation. The resulting hypochondriasis, though apparently identical with cases of hypochondriasis observed clinically in other patients, is an example of a syndrome whose meaning, cause, and prognosis is different from the type observed in individuals not traumatized in this fashion.

ASSAULT ON THE SUPEREGO

The selections by which prisoners lost their remaining love objects were ultimately responsible for their own survival, as a result of which there evolved the insoluble intrapsychic conflict now manifest as survivor guilt. The concentration-camp system also assaulted other functions of the personality. The loss of causality ("Hier gibt's kein warum!") and the reduction of the ego-ideal to a self-image analogous to that of a starved animal were accompanied by the total absence of any fairness, reason, or incentive. Deprived of hope, reduced to a state of paralysis or catalepsy, the prisoners developed a fatalistic

attitude and passively surrendered to the hellish existence to which they were subjected. The cannibalistic practices of S.S. commandants (e.g., in Buchenwald, where the wife of the commandant had lamp shades made of the skin of tattooed prisoners) further encouraged the regression of the superego function as was evident in the reports of instances of cannibalism among prisoners. The superego conflict was inherent in the situation in which, to survive, the prisoner had to engage in slave labor for the German Nazi machine which was destroying all those he loved, all that he stood for, and himself. There was always the unconscious idea that the death of one's neighbor satisfied the aggressor's lust for killing temporarily and thus prolonged one's own existence. This meant that the only possibility of survival depended on the patient's ability to temporarily suspend all superego function and achieve an ego and libidinal regression. Some who were successful in the regression were later unable to return to normal function—precisely because of the guilt produced by the compromising situation. Such an example was a Hungarian Jewish girl who was first raped and then regularly cohabited with an S.S. Scharfuehrer in Auschwitz. After her liberation she had a chronic, psychotic depression based on her feelings of guilt for *the way* in which she had saved her life.

The overwhelming of superego prohibitions, the frequently forcible perpetrations of acts against the most firmly established taboos and reaction-formations, were largely responsible for the setting up of pathogenic forces within the individuals which had to be dealt with at a later time. The Jewish Capo at the women's camp in Auschwitz in Barrack 18 (the assembly place prior to the gas chamber) was forced, as a price for her life, to load her mother and her sister onto the truck going to the gas chamber (Kossak, 1946). Would the memory of overt matricide and sororicide not be a force toward psychotic depression in her later life—if she survived?

The reaction formations which are most rigid and basic, such as those against dirt, soiling, and exhibitionism were attacked by the purposeful establishment of outdoor latrines, in which men and women had to evacuate their bowels in full sight of each other (Kossak, 1946), and into which they were often thrown. The cannibalistic practices which were the norm in concentration camps were set up in terms of the so-called Canada commandoes, a system whereby the old prisoners were given some of the food (and could

steal other possessions) of each new transport sent to the gas chamber and crematorium. In effect, the very core of superego and ego-ideal formation was systematically attacked and overwhelmed, at every stage, as a price of survival.

In reviewing those factors involved in the prisoner's ability to survive, Dr. Niederland pointed out that besides the purely accidental factors, those who managed to survive showed an unusual adaptability, alertness, and ability for quick decisions and execution of action that were decisive to their survival. The pertinence of this observation lies in the fact that *it is a rarity to observe among survivors any prepersecution depression or serious predisposition to endogenous depression or psychosis*. The existence of psychic conflict, repressed impulses, and even latent emotional problems is taken for granted. Joost A. Meerloo believes that obsessive-compulsive individuals had a better chance to survive, all other things being equal, because the persecution gave them a justification for hate of external objects. While we recognize that each participant in the concentration-camp experience, whether "active or passive," "persecutor or victim," lived his own psychic reality, we are trying to isolate some common denominators for the present study. The study of the fate of the aggressive drives in participants of the concentration-camp experience must be postponed for later study.

THE MUSULMAN STAGE

When the prisoner succumbed to the *psychic* assault upon his integrity, he showed a syndrome of terminal, irreversible depression, apathy, and withdrawal known as the "musulman stage." At this point, the prisoners no longer conserved their energies or tried to get food, but behaved in a way resembling marasmus in infants. The "musulman" was in a state of "apathy and psychophysical emptiness"; he no longer avoided blows or related to his fellow prisoners. Inasmuch as the "musulman" was doomed to die, the condition being irreversible, he was a threat to the defenses of denial and automatization of the other prisoners, and thus feared and shunned. Some authors who have themselves survived the concentration camp report that in some "musulmans" the onset of apathy was preceded by an outburst of indiscriminate rage against everyone, including their

fellow prisoners (Kossak, 1946). In dynamic terms, this suggests that the "musulman" may have turned his aggression against his self-representation, giving himself up to die, and forever losing his ability for enjoyment—perhaps in the sense of Jones' (1950) *aphanisis*.

Thus, Dr. Niederland concluded, the effects of the concentration-camp persecution could be summarized as follows:

1. *Survivor guilt*: often unconscious as a pathogenic force capable of producing a depression or anxiety, and consequently a wide variety of clinical syndromes.
2. *Chronic anxiety*: related to the confusion about the present and past, based on the unbearable nature of the past. This consequence is evident in the fact that whenever the concentration-camp survivors become anxious for any reason, the anxiety dreams with concentration-camp themes return, along with the persistence of tension states and startle responses.
3. *Physiological changes*: apparent in terms of chronic tension states and various types of vegetative dystonia. Some aftereffects are very specific, e.g., cirrhosis of the liver secondary to starvation; others are vague, e.g., those related to headaches, muscle tension states, "busy leg" syndromes, heartburn and even peptic ulcers.
4. *Disturbances in intellectual function*: problems such as memory distortions (*hypermnesias* or *amnesias*), distortion of the body image, and temporal confusion as evident in frequent *parapraxias* related to time.

WORKSHOP DISCUSSION

In discussing Dr. Niederland's paper, Dr. Krystal pointed out that for the purpose of this discussion Dr. Niederland has selected one aspect of the experiences of the victims of Nazi persecution—the concentration-camp episode. Dr. Niederland was able, by so doing, to present an extremely clear and psychodynamically understandable picture of the effects of the concentration-camp traumatization. For the sake of completeness, it is necessary to add that the migration itself can represent enough of a psychic trauma to produce a wide variety of emotional problems (Krystal and Petty, 1963). The effects of uprooting were highly pathogenic, frequently resulting in severe

depressive reactions (Strauss, 1957). There have been attempts to classify the syndromes by severity of pathology and to correlate these with age or duration of persecutions (Bensheim, 1960). The latter attempt loses sight of exactly what Dr. Niederland stresses: namely, the dynamic forces involved in symptom formation. The persecutions forced survival by regression, which, in turn, revived unconscious fantasies and conflicts of intersystemic tension, consequently imparting to them the force of reality (e.g., the Nazis' exploitation of the fears of loss of identity). The sight of the automatized prisoners—uprooted, having given up their families, self-respect, and acting as though any opposition to the Nazis and/or individual self-assertion was impossible and unthinkable—impressed itself on the new arrivals. Thus the S.S. utilized some prisoners like the Judas Goats of the slaughter houses.

In the discussion, some of the many factors influencing the nature of the late sequelae of massive psychic trauma were considered. It was decided that the workshop would devote itself to the study of four patients.

CASE PRESENTATIONS

The first patient was presented by Dr. Emanuel Tanay. The case was selected because a reaction became apparent *after* the patient received a pension. This is pertinent to the forensic question of "Renten-neurose"—the influence of the desire for a pension as the determinant for the patient's symptoms. Dr. Tanay's presentation follows:

This is the case of a middle-aged woman from Eastern Europe who was referred to me in July of 1960 with a history of recurrent episodes of depression. However, at the time when I first saw Mrs. L. she was in a manic state, highly agitated and preoccupied with delusional ideas centering around the Nazi persecutions. At first, her delusions were exaggerations of some possibly realistic experiences. She also referred to various people as being Nazis, or felt that they were this or that Nazi official. The patient was hospitalized in a private hospital, where she continued to be delusional and was unresponsive to extremely high dosage of medication. Her delusions slowly changed into identification with the Nazis. She spoke of the fact that her father was the high German official. She

insisted that the nursing supervisor at the hospital was really Hitler in disguise. The patient also was preoccupied with a delusional belief that she was pregnant. Her agitation slowly subsided and she entered a state of severe depression, during which she was easily tolerated by the family so that she could be considered "cured."

In July of 1961, the episode of manic behavior recurred and, at this point, the possibility of "anniversary reaction" was considered. History from the husband confirmed this suspicion beyond any doubt. It seems that for years the patient had been disturbed during the summer months. On further questioning of the patient and the relatives, it was learned that the patient had a five-month-old child who died in her arms while they had been on the so-called death march. This occurred in July of 1942. The patient felt that she was responsible for the death of the child because while they were on the march she was permitted by the German soldier to enter a peasant house and feed the baby. The peasant woman offered to take the child from the patient and return him after the war. The patient refused the offer; a few days later the child died in her arms.

In the spring of 1962, the patient developed another manic episode. This time her illness was, so to speak, "out of season," which was not in keeping with my previous experience with her. Once again she was delusional but appeared to be preoccupied primarily with her trip to Israel where she was to meet some of her relatives; she made repeated reference to a certain sum of money for the trip, plus various gifts she would take which would total that particular amount. She would stick to a certain specific figure that she would spend on this venture. At one point, she said that this is the amount that she "had to spend." When this was followed up, it turned out that *the amount that she was about to spend was exactly the same sum of money that she had received recently from the German government as restitution*. It was pointed out to her and she had become aware of her guilt for having received some money, an interpretation which ultimately stated that she had been paid for her child's death. Following this clarification, the patient "recovered" from her manic episode, and returned to her usual state of chronic depression.

In direct contradiction to all the concern that the symptoms in the concentration-camp survivors may be a "Renten-neurotische Zweck-Reaction" (von Baeyer, 1958), the above patient was unable to accept any money from the German government. This act became linked in her mind with her survivor guilt, which became unbearable when she recognized her feeling that not only had she allowed her relatives and child to die, but that now she was even receiving money for them from the "Restitution" authorities. Obtaining a

pension brings identification with the aggressor nearer to consciousness, and with it the guilt over survival priorities. Survivor guilt, the result of universal ambivalence, often makes the acceptance of any compensation a traumatic event for the survivor. Some cannot bear it at all because they feel that to become dependent for support on German authorities involves an additional humiliation to them.

This patient's reaction to having received money from the German government was a logical consequence of her guilt feelings. For defensive reasons, money had to be spent on some "worthy cause," like a pilgrimage to Israel and gifts for her family. The restitution money had revived guilt feelings that became overwhelming and precipitated manic denial.

In the process of the discussion, the point was made by Dr. Grier that in turning the aggression against the self and assuming a position of identification with the aggressor, the patient's behavior resembled that of brain-washed soldiers, who after a prisoner-of-war experience tended to identify with their captors. This was confirmed by other discussants in pointing out that prisoners in concentration camps, whether political, criminal, or any other type, gradually *assumed* the code and even the mannerisms of the S.S. guards.

The second case was presented by Dr. Bruce Danto:

The patient was a 32-year-old woman who was admitted to the Detroit Receiving Hospital following the ingestion of 40-60 tabs. of Phenophen (a compound of salicylates and barbiturates) in an attempt of suicide. The patient was rescued by her adolescent daughter who, upon returning home from school, could not get in. Suspecting that her mother was home, she called the police who broke down the door and found the patient unconscious next to a note which read: "Do not forget me." The history as obtained from the patient, her husband, and daughter was as follows:

The patient was granted a 25 per cent disability from the German Restitution Authorities. Despite many attempts to explain the contrary, she developed the delusion that this money was given to her because she had cancer. A few days later, the patient received a "pink slip" requiring that, as a recipient of the pension, she prove, by a notarized signature, that she was alive and residing at her home address. She then panicked, feeling that the Nazis had now caught up with her and would get her deported from the U.S.A. or killed. While the patient had some symptoms related to her guilt and fear of retribution ever since her liberation

from the concentration camp, the major outbreak of symptoms actually preceded the receipt of her pension. The patient's major break with reality came about at the time she was getting United States citizenship. It was then that she started feeling that her husband was trying to get rid of her in a variety of ways, and soon, that everyone she knew—all their friends and acquaintances—were co-conspirators in this. She felt she could discover this by the way other people looked at her or talked about her. Between this time and the time she received her pension, she became gradually more fixed in her delusions that she had cancer of the stomach.

In the present interviews, it became apparent that this delusion, while overdetermined, was to a significant extent related to the patient's survivor guilt, as she stated that the cancer of the stomach was caused by what she ate in the concentration camp, namely, while she was a cook. In fact, the patient, as a young and healthy girl, was selected to work in the kitchen, which assured her of having access to enough food to retain her strength. She did help her relatives, but most of them perished anyway and the patient blamed herself for this. Since the patient's marriage, she consistently complained of nightmares involving uniformed Germans who were "coming to kill [her]."

Dr. Krystal then reported having examined the above patient about one year prior to the present illness, as part of the medical workup in relation to possible health damages. At that time, Dr. Krystal found that at the age of 11, when the patient was put in a ghetto, she was a well-functioning youngster, without any evidence of neurotic traits or hereditary taint. While in the labor camp, during the typhus epidemic there was a "grand selection" during which all three of the patient's sisters perished. The patient was alert enough to escape and hide in a forest and to return to the camp later. This event represented another "kernel of truth" of her survivor guilt.

After the liberation, she began having episodes of depression and anxiety, as well as a diffuse "nervousness." She and her husband emigrated first to Israel, and from there to the United States. After settling down in Detroit, the patient developed a plethora of somatic complaints, e.g., headaches, "choking" in her throat, as well as outright neurotic traits such as anxiety, insomnia, and nightmares. It was noted in the course of the examination that the patient's relation toward her husband (and the examiner) was a "demanding passive attitude," a "clinging and demanding character structure." It was also noted that the loss of her father and three sisters in her adolescence had set up a problem of survivor guilt of serious proportion. The report read: "At present, this guilt is evident in the patient's anxiety and generally fearful and worried out-

look. The depression may, however, become directly evident with either paranoid or masochistic features."

PATIENT INTERVIEWS

Two patients were then introduced and interviewed. The first patient, Mrs. K., was interviewed by Dr. Niederland:

Mrs. K. was quite tearful, explaining that on this day she would have celebrated her younger son's twenty-first birthday, had the Nazis not killed him. The patient, a 49-year-old woman, was neat, attractive, and alert. During the Nazi occupation her husband was appointed to the "Judenrat" (a Nazi-picked Jewish Community Council) and was used as a scapegoat when the Nazis were taking vengeance on the Jewish community. When asked to describe her pre-war circumstances, the patient was quite modest (e.g., she said, "We were in the dry-goods business," when actually her husband was a manufacturer and a man of considerable means), but it was apparent that the patient had functioned on a well-adjusted level.

During the "action" in which most of the Jews were sent to the death camp in Maidanek, the patient gave her older son to her mother-in-law to hold, while she herself carried the younger one. An S.S. man demanded that she give up the child, and when she refused, he screamed at her: "Schmeiss den Dreck weg!" (throw away that shit!). When the patient still refused to part with her child, she was beaten to unconsciousness, after which the child was taken away from her. This incident became hypermnesic and part of her nightmares to date. The children were sent to the "experimental" camp at Chelmno, where they were all killed in trucks in which the exhausts had been connected to the air-tight wagons.

The patient and some members of her family were sent to the ghetto in Lodz. Upon arrival, the patient was still confused and depersonalized; gradually, as the acute brain syndrome wore off, she became severely depressed and withdrawn. She was very suicidal and survived only through the efforts of her sisters. When transports were being evacuated from the Lodz ghetto as part of its gradual liquidation effort and the liquidation of Polish Jewry, the patient kept volunteering to be sent away in the vain hope of being reunited with her two lost sons.

Eventually, she "got her way" and was sent away—straight to the Auschwitz concentration camp. There, in 1943, she went through another "selection" and was among the small minority which was left alive. She kept inquiring about her children in the beginning, but soon the

persecutions experienced in the concentration camp took their toll and she became like an automaton—no longer asking about them, knowing that they had been killed and yet not confronting herself with this knowledge. The business of survival had become much too pressing. At one of the numerous selections she had to endure in the Birkenau concentration camp, she survived only through a trick of covering with her hand a sore on her hip, so that Dr. Mengele missed it.

In December, 1944, she was among those who marched from Auschwitz to Gleiwitz in the first of the infamous “death marches.” Again, the patient was among the minority who survived. She was sent to Gross-Rosen, and then to Bergen-Belsen, two of the most deadly camps. The transport was one of those in which 100 people were put in a wagon in which there was only standing room for 80 (or realistic living room for 40 men or 8 horses, as stated in the famous inscription on the French railroads picked up by the American Legion in World War I). This meant that 20 people in each wagon had to die, and that their fellow prisoners, by pushing and stamping on each other, had to kill them. Here then is another “kernel of truth” in survivor guilt. Moreover, the prisoners were fed almost nothing for six to ten days of travel. When some bread was available, the Nazis did not take the trouble to give a piece of it to each prisoner personally, but threw a certain number of portions into the wagons. Some prisoners were too weak or apathetic to fight for their portions. Thus, even though there may not have been actual cannibalism, the prisoners, in their starvation and regression, were at times responsible for the deaths of weakened ones—by grabbing their portions. The patient’s recollection of this trip was hazy, except that she realized her being on the same wagon with her sister, and the two helping each other, probably accounted for her survival.

The patient developed typhus in Bergen-Belsen. She was so ill that, unconscious but still alive, she was thrown on the heap of dead bodies which had accumulated faster than they could be cremated. Her sister, however, discovered her, took her off the death pile, and nursed her back to “health.” When the patient related this part of her story, she broke out in a sob; the memory which so disturbed her was that this sister, who saved her life, died herself of typhus and exhaustion a few days after their liberation. The patient produced a photograph of her lost sister, exclaiming, “What a nice looking girl my sister had been—what a loss!”³

When liberated by the British troops, the patient weighed 80 pounds and required hospitalization. After a few weeks of convalescence, she

³ Dr. Niederland commented on the use of the photograph as a reflection of the hypercathexis of the body-image in concentration-camp survivors.

met a man who had just returned from their home town. She then had to confront herself with the loss of her children, husband, siblings, parents, and all other relatives. The patient became severely depressed and withdrawn. Luckily, some time later her two brothers, who had survived after years in the forests where they waged guerrilla warfare against the Nazis, found her and took care of her. About this time, she met her present husband who had also lost his wife and children. Out of mutual pity, they entered a marriage which is an unhappy one. The patient feels very disappointed with her husband, who is a weak and "broken" man.

Dr. Niederland then obtained a history of symptoms of anxiety and depression which have persisted with periodic exacerbations subsequent to the patient's liberation. The presenting symptoms included the aforementioned periodic depressions, insomnia, nightmares and anxiety dreams, as well as tension headaches and joint and muscle aches. She further complained of heartburn and epigastric distress. The interview further revealed that neither the patient nor her husband had the capacity left to enjoy life. They never did anything "for fun" nor could they allow themselves any pleasure or joy—protesting that this proved impossible for them because they had nothing to live for, having lost their spouses, children, and families. Mrs. K. revealed not only very intense survivor guilt, blaming herself for the death of her children and sister (who had saved her life), but also a feeling of resentment for the loss of status in life and a lack of aim or meaning in it. This was uttered in a variety of ways, such as "What did [she] do to deserve such a total devastation of [her] family? Why did [she] have to survive? What is the use of it all?" The themes of resignation and turning the aggression against the self were persistent and dominated all of her moods and cognition.

There followed a discussion of the patient's symptoms as an example of the typical concentration-camp survival syndrome. The pathogenic effect of the survivor guilt was stressed (Trautman, 1961; Eitinger, 1961). It was also pointed out that in her turning the aggression against herself there were observable not only the depression and anxiety produced by the guilt, but the picture of what European psychiatrists call "neurovegetative dystonia"—namely, the production of somatic symptoms related to anxiety, or autonomic nervous system dysfunction (Eitinger, 1961).

Dr. Krystal then interviewed and presented the case of Mrs. D., a woman whom he had interviewed previously concerning her pension, and who at the time of the present interview had already been collecting a pension for health damages:

The patient, Mrs. D., appeared in the company of her husband, upon whose presence she insisted during the present interview, as she had during her previous interviews with Dr. Krystal. She was an attractive woman of 34, slightly obese, well oriented, and cooperative.

Dr. Krystal directed the interview toward the patient's experiences under the Nazi rule. She stated, after relating her experiences in the Lodz ghetto, that at the age of 15 she was sent from the ghetto to a camp in Chelmno. At this point, Dr. Krystal encouraged the patient to describe the camp, to which she replied that it was a farm and that she worked on this farm as an agricultural worker. However, because of previous knowledge that Chelmno was, in fact, a concentration camp in which 180,000 Jews were killed in prison gas vans (this was revealed at the trials of S.S. men Ernst Baumeister, Kurt Moebius, and S.S. Colonel Bothman), Dr. Krystal persisted in asking the patient to describe what she saw there. The patient became very anxious, cringing with every motion or question of Dr. Krystal's, but consistently denied having seen or heard anything at Chelmno contrary to the fact that it was a "farm."

She then stated that she was sent from Chelmno to Maidanek, where she worked "packing clothes"—her denial of awareness that the clothes she was packing had belonged to the more than one million Jews who were killed there was again stark and persistent. She did, however, relate some of the procedures and ordeals she went through at Maidanek, where she was in the special commando for young girls who sorted and packed the clothes left by the Jews killed in the gas chamber. The girls were not only periodically submitted to "selections" in the nude—where those who appeared weaker or for any reason unappealing to the selector were murdered—but, in addition, there were periodic decimations; in fact, half of the girls were sent to the gas chambers at a time. Since either the even or odd numbers were selected for death, the girls often panicked, pushing each other from their places in line. The patient described the process of automatization in herself. When asked what accounted for her ability to survive in preference to some of the other girls, she said she had wanted to live "to see [her] mother" (the latter had actually been killed before the patient was sent to the first camp).

Dr. Krystal, in discussing this case, pointed out that he had selected this particular patient to demonstrate some of the difficulties involved in taking a history from these patients. Besides the memory distortions already described by Dr. Niederland, here was a patient who so heavily denied her past that she may never be able to tell anyone, or even know consciously herself, exactly what happened to her. As Dr. Niederland has shown, to say she "was two or three years

in concentration camps” gives neither an indication nor a clue of anything that really became pathogenic to her. While this patient can give us no hint of her psychic reality of these experiences at the Lodz Ghetto, or at the extermination camps at Chelmno and Maidanek, we are given a hint of what she witnessed at Chelmno from a description by Adolf Eichmann (Arendt, 1963):

The death camp at Chelmno (or, in German, Kulm) where in 1944 over three hundred thousand Jews from all over Europe, who had first been “resettled” in the Lodz Ghetto, were killed. Here things were already in full swing, but the method was different; instead of gas chambers, mobile gas vans were used. This is what Eichmann saw: The Jews were in a large room. They were told to strip. Then a truck arrived, stopped directly at the entrance of the room and the naked Jews were told to enter it. The doors were closed and the truck started off. “I cannot tell how many Jews entered,” Eichmann recalled. “I hardly looked. I could not, I would not, I had had enough. The shrieking, and . . . I was much too upset, as I told Muller when I reported to him. He did not get much profit out of my report. I then drove along after the van and then I saw the most horrible sight I had thus far seen in my life. It (the van) was making for a long open ditch; the doors were opened and the corpses were thrown out, as though they were still alive—so smooth were their limbs. They were hurled into the ditch and I still have visions of how a civilian with tooth pliers made extractions. And then I was off—jumped into my car and did not open my mouth anymore. Since that time, I could sit for hours beside my driver without exchanging a word with him. There I got enough. I was finished. I only remember that a physician in white overalls told me to look through a hole into the truck while they were still in it. I refused to do that. I could not. I had to disappear [pp. 82-83].

If this is the way Chelmno affected “soft-hearted” Eichmann, what could have been its effect on a 15-year-old girl whose parents and siblings had just been killed in some gas chamber?

The problem of survivor guilt was again apparent in the patient’s feeling that the only justification for her survival was an idealization of her attachment toward her mother. As has been previously described by Rosenman (1956), we are dealing here with historically determined phenomena of massive guilt in disaster survivors, which also affords an accommodation of their anger toward providence or

God for allowing such calamity to befall them. The fact that the patient had not been able to deal with her ambivalence successfully, however, was apparent in the fears that she developed whenever her love objects (husband or children) were out of her sight.

The patient also showed a disorientation as to dates, especially confusing the decades, as had been pointed out by Dr. Niederland. Dr. Niederland, in discussing this case, related the genesis of the patient's present hypochondriacal preoccupation to the "selections" and to the urgent dependency on the *appearance* of her body as it directly affected her survival. The loss of causality and the killing of every second girl in Maidanek imparted the stamp of reality to the patient's fears of her aggression, thus making it impossible for her to deal with her magical thinking or ambivalence. In questioning this patient, as well as the previous one, Dr. Niederland was able to demonstrate that they have episodes of such vivid revival of fears and memories of past traumatic events that at times, upon awakening from an anxiety dream or even when wide awake, they are confused as to the time and place, actually believing themselves to be back in the concentration camp.

The patient's need to have her husband with her at all times was part of a transference relationship. Despite all manner of reassurance, she continued to experience the examiner as identified with her former persecutors. She vividly acted out her terror of a physical assault by actually cringing every time a question was asked.

All the patients presented to the workshop showed a variety of disturbances of their sexual function. They were frigid, unable to reach an orgasm, and showed an infantile and sadomasochistic attitude toward sex. Although such regressions have frequently been noted in the literature (Eitinger, 1961; Friedman, 1948, 1949), the point is brought up here, because of a uniform belief of an almost delusional intensity reported by both patients—namely, that they knew for a fact that their menstruation had ceased after arriving in the concentration camp because a "medication was being added to the bread" to stop their "periods."⁴ Here was a delusion—yet of a different dynamic background—which therefore implies a different

⁴ Zofia Kossak (1946), a Polish writer who was imprisoned in Auschwitz, was more specific on this subject. She believed that "salicylates and saltpeter" were added to the food to "suppress the menstruation" and increase the ill effect of sexual deprivation. Actually, castration anxiety and identification with the dead was manifest in this symptom, as revealed later in survivors (J. A. Meerloo, private communication).

prognosis than is customary in psychiatric practice. This delusion makes reference to a regression to pregenital striving exclusively, which took place in the concentration camp in the interest of survival, and to the lessening of the pressures upon the ego. This was practically verbalized by other prisoners who believed that "if one got sex in the concentration camp, he got weak and perished" (Friedman, 1949). It should not be assumed that this regression had no pathogenic potential, for the very man who made the above statement became impotent when interned by the British at Cyprus, although there was no danger to his survival at this time (Friedman, 1948).

IV. Dynamics of Post-traumatic Symptomatology and Character Changes

INTRODUCTION: SELF-INSIGHT AND DEALING WITH VICTIMS OF PERSECUTION

JOHN M. DORSEY, M.D.:

Shakespeare often had an unlikely dramatic character make profound statements, a practice that has puzzled many a reader. For instance, why would he have Polonius, a court politician, disclose that precious insight, "To thine own self be true, and it must follow, as the night the day, thou canst not then be false to any man?" Or, why did he choose Mark Antony to deliver such remarkably dry humor, when with Lepidus on Pompey's galley, he described the crocodile as being in every way like itself? Or, why did he put in the mouth of young and tender Romeo that marvelous bit of veteran wisdom, "He jests at scars, that never felt a wound"?

In a way, I too feel unlikely, even as a displaced character, speaking on this subject which duly requires such a tremendous amount of experience in suffering—in *conscious* suffering. I think of myself, of how I treat myself when my life seems to have the illusion of tragedy about it. I speak of the "illusion" of tragedy, for I have found out that all tragedy is illusional.

On the one hand, I have to live myself as a person realizing that my world is really wonderful, after having arrived at that truth through being a scientific fact-finder. The scientific principle states: Taking into consideration that certain events have happened, and that conditions are what they are, nothing else can then occur but what does occur. In that realistic sense, whatever I live is desirable, certainly. On the other hand, I have to live myself a feeling man, realizing that my personal experience may at any moment exceed my

conscious endurance. My love is frequently so hard pressed that, instead of being the persevering kind of fact-finder, I fall away to become a fault-finder. Calling out that a thing "couldn't be, shouldn't have happened," is a form of crying out with pain, so that I can be easily tempted to succumb to being a chronic fault-finder.

In a topic such as this one (massive trauma), it is essential for me to try to hang on to myself, to keep my wits about me with extreme caution. The term "trauma" introduces an economic concept. It means my inability to sustain and keep my mental balance when the exertion I am undergoing, the mental excitation I am suffering, is more than I can tolerate and, at the same moment, arouse my awareness for my identity. Freud made this very clear to himself, so that everybody who would read of it could make it clear to himself if he wished. I refer to Freud's explaining the basis of really having a mental problem, the basis of neurosis, psychosis, of so to speak "losing one's mind." He showed "transference" to be the symptom formation occurring when one's experience exceeds the limits of one's conscious ego tolerance. He pointed out that every one of his associates struggled against his explanation of the mind (i.e., found it a traumatic experience) until that person had discovered through self-experience what transference meant. An appreciation of the economic role of transference is absolutely essential for an understanding of the meaning of self-analysis, or so-called psychoanalysis. Transference, as you have probably read or discovered for yourself, means living something of your life *as if it is not yours, as if it might not be all and only your life*. There is always a definite necessity to resort to this defense whenever it occurs, because one must, above all, preserve his sense of personal identity. This maintenance of my sense of organic individuality is tantamount, in my mind, to preserving my life. If I cannot experience something and at the same time see or imagine somehow the necessity for it, then I must reject it as being my own creation. The minute I say "not I," I start out on my psychological road of transference. Who is able to live an experience of concentration-camp living with the appreciation of his creating all the necessity for it? Certainly, I can hardly conceive of myself as being able to do it. And yet, as you have learned from your own experience, recovering your mental equilibrium means your being able ultimately to grow equal, to feel equal to the experiences you

have lived and for which, *therefore*, you are responsible. This is a moment to think of Romeo's expression, "He jests at scars, that never felt a wound."

At the end of World War II, everyone was appalled at the degree to which respect for the dignity of human individuality had been repudiated. It was as though appreciation for the dignity of the oneness of *all* human beings found sanctuary nowhere, not even in medical circles. Each member of the World Medical Association in General Assembly found it necessary to confront this most painful consideration. How could such human carelessness and recklessness have happened—particularly in any medical person? How could a physician lose access to so much of his own selfhood as to be unable to identify his patient with himself? How could a medical man, trained at one of our best American universities, assume any role in this kind of living? Well, after much study, it was recognized by somebody that if one is going to try seriously to fix responsibility anywhere, it has to be fixed solely within each given individual. There is no way of fixing responsibility on a so-called state or community. Such a displacement of one's own mental content makes it appear meaningless or "impersonal." Responsibility always accompanies authority, and each may only occur in an individual mind. Thus, coming to grips with this importance of *conscious* individuality and realizing the extent to which it was ignored, each General Assembly member finally responded with certain recommendations as to how this ever-ready conscious self-irresponsibility might be prevented or even tempered slightly in the future. One of the recommendations was called the "Declaration of Geneva." I look at the Hippocratic Oath; yes, it has wonderful tradition behind it, but does it contain enough respect and reverence for human individuality?

I encountered the situation of shirking responsibility very early in my career, by doing it myself. Later, in juvenile court and child guidance work, I observed my child readily accepting the attitude that he should not have done "the awful thing" he did. First, he may deny that he did it; the next step may be his feeling that he *shouldn't* have done it. But, his getting to see that he should have done exactly what he did, in view of the presenting facts of his life, that was the essence of his attempts at creating some self-helpfulness. If every German today were to recognize that everything happened the way it ought to have happened, it would mean that each German would

have to undertake a tremendous amount of self-education. It is much easier to be appalled by the "horror of the memory" and say, "it oughtn't to have happened." In my opinion, unless considerable effort such as you are putting forth today is extended, this path of least resistance will continue to be the chosen one.

I wish to recite the "Declaration of Geneva" in order to bring home the importance of conscious devotion to human individuality. I would like to have you pay attention to the extent to which the Declaration scores the words "I" and "myself." Dr. Editha Sterba has spoken of narcissistic hyperawareness of self. When my finger is pinched, or any part of me hurts, I develop a narcissistic hyper-awareness of myself; and my "others," of course, still being mine, nevertheless seem to be unimportant. You live consciously with what you call your others, I suppose, at least I try to. I frequently find it difficult but then that's something I haven't yet worked on enough. I haven't achieved the self-tolerance of that wonderful Jewish rabbi long centuries ago who said, "If I make my bed in hell, Thou art there" [his God]. It takes supreme insight and self-endurance to be able to live that way.

Here is the "Declaration of Geneva," which I have recommended be used at every medical gathering, as I am going to see it used here:

At The Time of Being Admitted as Member of The Medical Profession:

I SOLEMNLY PLEDGE myself to consecrate my life to the service of humanity;

I WILL GIVE to my teachers the respect and gratitude which is their due;

I WILL PRACTICE my profession with conscience and dignity; THE HEALTH OF MY PATIENT will be my first consideration;

I WILL RESPECT the secrets which are confided in me;

I WILL MAINTAIN by all the means in my power, the honor and the noble traditions of the medical profession;

MY COLLEAGUES will be my brothers;

I WILL NOT PERMIT considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient;

I WILL MAINTAIN the utmost respect for human life, from

the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity;

I MAKE THESE PROMISES solemnly, freely and upon my honor.

The law of humanity is the one law of devotion to the ethic: human individuality. The very fact that the question can arise as to whether the heroic kind of living to which one consecrated himself in "a concentration camp" is compensable, with or without so-called manifest neurosis, indicates the degree to which all of this unsung heroism is too painful to consider. So, once again, let me emphasize that I have to be constantly and consciously extending the boundaries of my tolerance; otherwise I will have to give way over and over again to the attitude that some aspect of the past was "undesirable," when it certainly was. Everything was there to make it exactly the way it was. What is extremely unpleasant to imagine, is that similar factors *necessarily* exist at present, in a degree often too horrible for me to face, right in my very own "land of the free."

THE EFFECT OF PERSECUTIONS ON ADOLESCENTS

EDITHA STERBA, PH.D.:

In 1930, Freud said in *Civilization and Its Discontents*:

We may shrink in terror at the thought of certain situations: that of the galley-slaves in antiquity, of the peasants in the Thirty Years' War, of the victims of the Inquisition, of the Jews awaiting a pogrom. It is still impossible for us to feel ourselves into the position of these people; to imagine the differences which would be brought about by constitutional obtuseness of feelings, gradual stupefaction, the cessation of all anticipation and by all the grosser and more subtle ways in which insensibility to both pleasurable and painful sensations can be induced. Moreover, on occasions when the most extreme forms of suffering have to be endured, special mental protective devices come into operation [p. 89].

At that time, Freud could say, "It seems to me unprofitable to follow up these aspects of the problem further."

Nowadays, we are not so fortunate as to be inexperienced in these aspects of the problem of happiness, for we meet many cases in our work which are the results of massive traumatic experiences during the years from 1933-1945. However, it is difficult to empathize correctly with the victims of these excessive traumatic experiences, and even those investigators who had some similar personal experiences may meet with a certain amount of reluctance to relive their own sufferings when they attempt to comprehend fully what the problems of the traumatized are and how they can deal with them therapeutically.

My own experience with aftereffects of massive traumatization pertains only to children and adolescents who were brought to this country as immigrants after the end of the Hitler regime. I was a consultant for the agencies in charge of placement of these children. Thus I had the opportunity to examine and study 25 cases of displaced youngsters, and to observe their reactions during the course of a few years. I have to emphasize that at the time of my consultations and observations no indemnification laws or compensation boards existed, and not much attention had been given yet to the psychiatric condition of the concentration-camp survivors. As far as I know, my observations were the first ones to be published in this country concerning the survivors of concentration camps. Some years before the end of the war, I was able to demonstrate, on the basis of my observations of some nontraumatized immigrants, that the loss of the homeland is experienced as an oral loss. It is experienced as the repetition trauma of weaning. I therefore expected that the displaced children would have a similar reaction to the displacement from their homeland; that is, I expected them to be depressed and to feel uprooted. I was not prepared for all the problems which the displaced children presented after they had been settled in a secure and stabilized environment. It was not possible to ascertain what criteria for the selection of these children were observed when they were chosen to come to this country. I assumed they were brought here because they were the neediest. Of course, they had to pass the health examination, and if they had seemed very disturbed during these examinations their immigration would not have been possible. The age of the group of displaced adolescents which I had occasion to observe was between 12 and 20. Both of their parents had been killed, either during the Nazi occupation of their country or had perished in concentration camps. All these youngsters had either

been in concentration camps themselves for 3-5 years, or had hidden in the woods during the time the Nazis had occupied their country. Many of them had lost not only both parents but all their siblings as well, during the occupation. Some of them were the only survivors of an entire village. All had lost their homeland forever, and had had to realize that a return to their home was impossible.

The first problem was that all of these youngsters were dissatisfied with their placement, although the foster homes had been carefully chosen and although, in many cases, the children were placed with near or distant relatives. Without exception, they all had expressed a wish to be placed in a family unit. Their complaints about the foster mother were almost identical. They were continually disappointed because they felt that the foster mother never did what she was expected to do for them. It was impossible to establish a good relationship with the foster mother, whether there were other children in the home or not. The children who lived with relatives never felt accepted. They were under the impression that they were unwanted, excluded, and "considered strangers." Although they were eager to be placed in a good foster home in order to "get mother-love," "to become attached," "to be able to be dependent," they soon were full of complaints about the foster homes. In one instance a child went so far as to call his foster home "a small concentration camp." Acting out of their constant dissatisfaction and disappointment was not uncommon—one boy became so aggressive toward his foster home that he purposely urinated on the floor of the bathroom, and made a habit of throwing matches and cigarette butts on the floor; another was so dissatisfied with his relatives that he refused to talk to them for two months. All the children claimed that the social agency which was in charge of them was negligent in its duties, did not provide enough money for their board, their clothing, or their other needs. In fact, they felt that the agency was there to provide everything they might desire. All the children wanted to change their foster homes. If their wish were granted and they were placed in another home or with other relatives, they soon raised the same complaints against their new placement. Others could not make up their minds to change because they felt it would be the same every place. One girl even admitted that she had *expected* to be unhappy in any foster home. Some went as far as to refuse to accept a new placement when it was offered because they did not believe

that their dissatisfaction could be diminished. The most astonishing fact was that, without exception, all of them complained bitterly about the food they were given; it was never what they wanted, it was not available at the time they wanted it, or the portions would be inadequate. Therefore, they considered the foster parents stingy; or they thought their own preferences and fads were not given enough consideration; or there was too much control, so they could not always raid the icebox when they felt like it. One of them said, "The agency wants me to starve and be miserable on \$25.00 a week." If they worked, these adolescents felt they did not receive enough money for their work. No job suited them because they always expected and demanded more than they got and were entitled to. In general, those who went to school did very well, but they expressed the same complaints against their teachers and peers which they ventilated against the people in their foster homes or against their relatives. These children also maintained the conviction that the foster home, as well as the school and job placement, might be better in any other city, particularly in New York—their debarkation point in this country, and a city for which they all had a great attachment. Some of them even tried to run away to New York, only to realize that their dissatisfaction would be the same. If one of the children had a friend or a relative from his homeland, with whom he had shared the terrible experience of the concentration camp or underground living, or with whom he had been in a displaced persons camp, he clung desperately to this relationship. The children made every effort to remain together, and if separation was necessary because one of them had relatives who took them in or one of them had to be in a different foster home, they refused to accept the realistic reasons for such a separation, often becoming depressed and sometimes unmanageable. As I mentioned before, the youngsters were orphans and had been shifted around so much that their background history was always very meager and superficial. Some were very reluctant to yield any material from their past because they evidently wanted to forget their horrible experiences. One of them said, "I would have to cry if I talked about my mother. I don't want to talk about my past. It will not bring my parents back again." We can easily understand that if one of them said, "I wish that I were a year old," or another female adolescent, "I wish I were a little girl," they wished to wipe out their childhood. They talked about their

past with utter hopelessness and depression. Here are several quotations, each of which is from a different child:

I shall never be able to recapture the years that I lost, or the love I did not get.

I hope my Aunt and Uncle will not be too affectionate, because they cannot replace my parents.

Nothing can ever be good again. If it is bad, it can become worse, and even if it is good, what good is it to me if my family is not here to enjoy it.

My heart is going to break because I am so lonesome.

I cannot forget my family. It will never be possible to replace the loss of my family.

All my happiness is gone forever.

These are only a few of the heartbreaking comments which we heard from them. One of the regularly repeated statements was:

One cannot forget what one has lost. I don't believe that my parents were shoved into the oven, although I saw it with my own eyes. When the war was over, I went back home hoping to find them.

One girl, the only survivor of her whole family, said:

Maybe it would have been real lucky if I had gone toward the left with my mother and the others when the Nazis in the camp separated the prisoners for gassing and for working. They are at peace, they have no struggles. Is it luck to have had to live in concentration camps and D.P. camps like I did? Not to know whether I would live or die from day to day? And to come out of it alone, and not to be with my family? I have often wondered if it would not have been better to have been taken care of by the Nazis, as my mother was. But, here I am and I have to live; what for?

Many of these children had the symptoms of *insomnia, restlessness, nervousness, stomachaches, headaches, constant fatigue and feelings of general weakness. They were frequently so depressed that they even refused to get help for these symptoms* (emphasis of the editor). A good illustration of this wide array of symptomatology presented itself during the analytic treatment of a refugee boy:

Robert, a 19-year-old refugee, was the oldest of five siblings. He had two younger brothers and sisters. The father had been deported and was later

killed by the Nazis. The mother fled with the sisters to another country; during the war, Robert and his brothers came to the United States. The mother and the two girls remained in Europe. When the mother died, after the war, the sisters came to the States. Robert arrived in this country when he was 12. From the time of his arrival, he was under the care of the same agency. He was particularly hard to handle and presented all the problems of other displaced children, only to a much greater degree. From the very beginning, he was defiant, insolent, and negativistic. He complained about everything and, in particular, was never satisfied with the food. For example, when he missed his orange juice one morning, he insisted on having a double portion the next morning. He never wanted to spend a nickel of the money that belonged to him. There were constant bitter complaints about his first foster mother, with the oft-repeated theme that she was incapable of understanding him. He even tried to get different jobs in order to avoid having to remain in the foster home and insisted on changing foster homes several times. Although constant supportive help improved his attitudes somewhat, he still had so many difficulties that I suggested he be taken into analytic treatment. After he had undergone the first nine hours of analysis, his two sisters, whom he had not seen for seven years, came to this country. He had been most anxious for them to be brought to this country ever since he had learned that his mother had died. During his first analytic hours, he spoke very little about his family, and showed no feelings about them; however, he left for New York in order to meet his sisters. When he returned with his sisters, they were placed in a foster home only a few blocks away from where Robert lived. Robert had been hoping all the time that the agency would allow him to rent an apartment, where he could live with both of his sisters. He came for his analytic hour on the day he returned from New York with his sisters; for a few minutes he spoke quietly about how wonderful they were. After that, he began to attack the agency, loudly and with great anguish, for not allowing him to live in an apartment with them. He started to complain violently about his loneliness and his inability to sleep. "I can't go home, they have been taken away, my own flesh and blood. I want to do things for them. I want them for myself." He also raved and ranted about his relatives in New York, who had now told him the details of his mother's death. "I don't want to know that she's dead. Why don't they stop talking about it?" Robert was also very upset and bitter about the fact that his relatives had given his sisters many things, whereas he himself had no money to do anything for them. He said, "I want to bring them up as my own. I have the right to have them." He talked about them as if they had never been separated from him. His sisters had been saved from the Nazis and he did not want to

be separated from them again. He finally said, screaming and sobbing desperately, "What good is it to bring them over, then take them away again? Life could be something, but now it's lonely, empty, worse than before. They are close and yet so far." After this outburst, he started to sob uncontrollably. It took half an hour to quiet him down so that he could talk again. Robert had found his sisters, from whom he had been separated for many years, and was to live with them in the same neighborhood. Why did he react so violently to the fact that they would not live entirely with him, but only a few blocks away from his home? It was obvious. The arrival of his sisters brought back to him all the pain he experienced when he was separated from his parents—first from his father and then from his mother. He had not yet been able to accept his mother's death at all. This was shown clearly when he said, "I don't want to know that she's dead." He thought his sisters were wonderful and he wanted to be with them because this would give him the feeling his family unit was still complete. He never had this feeling when he was with his brothers; the sisters however, represented the mother for him, because they had been left with her at the time he was separated from her. When he claimed that he had the right to have them, he meant that he had the right to have his mother, whom the Nazis had taken away from him. And when he said life was worse because his sisters were separated from him, although they lived only a few blocks away, this meant that now he had to realize that he had lost his mother irrevocably. The aggression and hate against the agency, which in reality had no alternative placement for the sisters, was an expression of his aggression and hatred against the Nazis who had killed his parents. An aggression which, together with all his feelings, he had to repress, and which only now came out fully. The fact that he talked about his sisters as if he had never been separated from them proved he had accepted neither the separation from his mother nor her death, because the relationship to his sisters when he left them upon coming to this country was not so important as he had now made it seem.

A. Freud, in collaboration with S. Dann (1951), reported that the orphaned six Bulldogs Bank children, who grew up motherless and as rejected infants, had symptoms which were the same as I have described with these displaced youngsters. "They were hypersensitive, restless, aggressive and difficult to handle." The observations I made with the displaced children seem to me of particular importance for the evaluation of emotional disorders in adult survivors of Nazi persecution. Unlike adults, who had a symptom-free period, the children survivors of concentration camps developed emotional dis-

orders as soon as they were settled in this country, as soon as they realized that their fate was final, that no change was apt to be expected, and that *none* of the missing parents or relatives would ever return. Their neurotic symptoms were manifestations of their reactions to the horrible experiences in concentration camps, where their weak and immature childhood egos, having been taxed to the limit, had to mobilize all available defenses in order to survive. Under the constant threat of annihilation in the camps, the egos developed an "emergency regime" which broke down and fell apart immediately, as soon as the constant pressure to control one's reactions in order to survive was relieved. It is to be expected that an adult, whose ego is stronger than a child's, whose defense mechanisms are more entrenched, would not display the same symptoms immediately after having been settled.

These youngsters had been exposed to constant frustration and cruelty. They had to strain to the utmost to endure all of this in order to survive. However, the moment they felt safe, all the pent-up emotions broke loose and they demanded immediate and insatiable gratification of all that had been denied to them. Now, they could dare and afford to develop neurotic symptoms, which they had had to check with all their might in order to survive. Former concentration-camp inmates and displaced persons who come to this country may not break down and display their neurotic symptoms immediately. As long as they can keep the illusion "that, in America, everything will be wonderful, all expectations will materialize, I will be compensated for all my sufferings," they will be able to function relatively normally. The ego strength of the grownups and their successfully established defense mechanisms, will determine how long they will remain free from neurotic symptoms, and how long it will take them to realize that what they really want is impossible—namely, that their horrible experiences and unbearable sufferings should be deleted and life should start anew without this past. The symptomatology caused from the massive traumatization will then become manifest. Significant in the dynamics of their neurosis are the guilt feelings for having survived their family members and the self-reproach for not having tried hard enough to save some of them. It is still our part, through further exploration, to understand what destructive influence these massive traumatizations may have had in the different phases of development of these youngsters, and how

their latency period, their prepuberty, their puberty were affected. Complete suppression of all emotional reactions was a necessary prerequisite to survival. It is to be expected that all displaced adolescents will have to make up the working-through of their puberty problems after their liberation which, as a result of the loss of the parents and because of all the feelings connected with this loss, had made impossible the emotional maturation of these children. If we examine the therapeutic possibilities for these massively traumatized persons, we may find it useful to apply Freud's concept of complementary series to the psychodynamic situation of each case. We can safely state that, in general, the more neurotic the pretraumatic personality was, the more difficult it will be to treat the results of the massive traumatization; however, there may be exceptions. We know from Greenson's paper on "Apathy" (1949), that this type of neurotic defense, which was established against childhood traumatization, may be of excellent use during and after most traumatic experiences. The defense which we might call narcissistic hyper-awareness of self and of others may have occurred in the sense which Bettelheim (1960) describes in his book. Thus we come to the conclusion that here, as in so many—or should I say in all instances—generalizations have to be left wide open for exceptions and corrections.

DR. KRYSTAL:

Dr. Sterba has, as was anticipated by all of us, given a very lucid account of some of the most difficult problems; namely, the problems of the survivors who were in their adolescence during their concentration-camp experiences.

The example of the boy who said that he didn't want his foster parents to be nice to him because he didn't think that he could feel anything good toward them was the most poignant presentation of survivor guilt that I have ever heard. Ultimately, he was expressing the unconscious statement that he would be showing infidelity to his mother if he accepted the love of his aunt. This sentiment is an attempt to avoid confrontation with the ambivalence, or more specifically the repressed aggression against the lost parents.

Another point which is extremely important was the observation that Dr. Sterba has made—namely, that these very lonely youngsters, after finding someone to love and someone to love them, proceeded

to fulfill the next most important need—finding someone to hate. We find, as both Dr. Niederland and Dr. Tanay have pointed out, that the problems of the survivor are primarily and to a large extent problems of aggression that had been unable to find expression until the safety of the survivor was obtained. This point has to be kept in mind in view of a corollary of Dr. Sterba's presentation: that the aggression in the survivor family, as well as the delayed work of mourning and adolescence, produce a syndrome of explosion in the families of survivors. The adults may completely suppress their aggression, but their children, born in this country, develop aggressive and delinquent behavior. In this way, the aftermath of Nazi persecution is already affecting the next generation.

EMANUEL TANAY, M.D.:

There is one aspect of what Dr. Sterba has presented which is of particular interest to me—the apparent difference between these children and the adults that we see. Adult survivors do not express aggression in that form. They direct it mainly toward themselves, and they are not dissatisfied with the treatment given to them. They think everything is too good. When you see many of these patients, they “break up” when they give you an account of someone being nice to them. One can precipitate an emotional crisis for a survivor in an interview situation by simply bringing up some occasion during which he had been treated well. Again, I think that has to do more with aggression. You mention the child who said: “I don't want my aunt to treat me well.” I think this was a reaction more characteristic of adults—not being able to accept kindness because of unconscious guilt, secondary to repressed aggression.

AN INTERPRETATION OF THE PSYCHOLOGICAL STRESSES AND DEFENSES IN CONCENTRATION- CAMP LIFE AND THE LATE AFTEREFFECTS

DR. NIEDERLAND:

As we all know, to discuss psychiatric disturbances encountered in survivors of persecution is an arduous task. Because it is difficult to view these conditions from a clinical viewpoint only, separate

from the broader historical, social, and basic humanistic issues, I am happy that Dr. Dorsey preceded me in his presentation because he stressed these more fundamental issues, apart from the clinical one. As a clinician, it is most difficult to preserve that traditional equidistance of activity which is considered the hallmark of good psychiatry but which, at times, is impossible to maintain or even to expect in the face of the most inhuman types of treatment inflicted by men upon their fellow men. In examining a great many survivors of Nazi persecution for forensic psychiatric appraisal, I have again and again become aware of our consistent incapacity to imagine, much less to evaluate, the nature of the experience.

The difficulties here are manifold, and in trying to understand them, my first realization was that the experience, as such, cannot be communicated apparently. It cannot be expressed or described in words. Indeed, in our clinical contact with these patients, it is difficult and almost impossible to gather clear-cut material in most cases. The quotations which Dr. Sterba gave us are fully penetrating, and illustrate a number of the problems we see later in adults and in the psychiatrists who try to work with them. The denial (I will discuss this in greater detail later), "It cannot be true," is not only, as Dr. Sterba told us, the defense of the patient but also of the one who listens to it and has to deal with it diagnostically or therapeutically. "Insofar as it cannot be true," a kind of tacit agreement is reached between the patient and doctor—an agreement to gloss over, and thereby ignore the potentially traumatic data. As I reported before, this problem leads to a way of dealing with all other aspects of that traumatized individual's experiences in life, in an almost tragi-comic fashion. It is of interest to note that among the excellent, carefully detailed hospital records from a good hospital of several such patients, one finds in a 12-page report of such a patient, all the details about his childhood illnesses, the condition of the grandfather, the grandmother, and the patient's early and later masturbation; but, about his five years in Auschwitz, having lost all his relatives and being the only survivor of a family of 91 people, there is one line—I repeat, *one line*, in an otherwise comprehensive hospital record. Specifically, the one line says, "This man was in Auschwitz five years." Before he came here, and while he was here, he saw before his own eyes his brothers, sisters, whole family or part of his family transformed into lumps of flesh and blood. One of his

children was lying before him, transformed into such a lump. The patient stood there helplessly because two others held him; otherwise he too would have been killed for trying to resist cruelty. This material had not been brought out because the doctor was afraid to deal with it in his own mind. In other words, the doctor is as hesitant as the patient to open up these experiences which are clearly stated before our eyes, and visible in a hospital record. However, there is even more than the denial as such: that is, in essence the formulation is "It cannot be true; it must not be true."

There is a second point: that many survivors refrain from speech because, perhaps, they no longer believe in words. It is to be expected that those who actually emerged from the lowest depths, where their families, often before their eyes, have perished, will be unable to translate their experiences into words. When they do emerge out of their depths, and when it becomes necessary for them to express themselves, for instance, during the medical psychiatric evaluation and appraisal toward their compensation claim, they cannot go through with it. They remain silent; or sometimes, when one has patience with them, they start speaking haltingly and hesitantly, as if they were reluctant witnesses to some obscure, inexplicable shame and guilt. Here, permit me to enlarge on the scene of the concentration-camp survivors and persecution survivors we are dealing with here today. Included also is a newer research amongst the survivors of other disasters, for instance, those of the atomic bomb destruction at Hiroshima. In 1961-62, Dr. Robert J. Lifton of Yale University embarked upon a research project in Hiroshima, where he found exactly the same situation among the Japanese, a people of a completely different culture. The survivors feel guilty; they are ashamed to talk about the rows of corpses that they saw there, twisted into the most horrid, distorted positions. Even today, it is difficult to encourage them to talk about it; when they do, they speak in a guilty, halting, shamed, and embarrassed way. Dr. Lifton has stated that it appeared to him to be one of the cruel ironies of the tragedy that the survivors feel guilty about what happened. In Germany, we don't always find the same guilt among the perpetrators of the crimes, who still use such rationalizations as, "they were forced, they were told to do so, they only carried out orders," etc.

The third point I want to make concerns the "flight from the

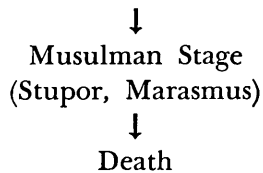
horror" which they survived, and which seems to produce in the observer similar tendencies to gloss over the experiences that the victim underwent, as previously mentioned. Here also, we have to extend the important forensic psychiatric fact. I believe that only in this way can we understand, in our appraisal of these people, the mental condition from which they suffer today: this survivor syndrome which I have described as a clinical entity. It is true that their present mental illnesses, which center on the survivor syndrome, on chronic depressions, on severe neurotic, sometimes psychotic pictures, are correctly clinically diagnosed. However, the etiology of these conditions has all too frequently been attributed to the "Anlage," the constitution, to other events, endogenous factors, or to the abuse or misuse of psychoanalytic concepts, to something which went on between the survivors and their parents during their first and second years of life. It seems hard to believe that the four or five years in Auschwitz, with total or almost total family loss, the complete degradation to the point of dehumanization, the chronic starvation and deprivation of everything human, are considered incidental factors, so to speak, in fully-stated medical psychiatric opinions for the courts. Against this background, and with our incapacity to comprehend, to imagine the nature of the experience and the frequent incapacity of the victims to express in words what happened to them, an attempt on our part must be made to acquire a fuller knowledge of the nature of the experiences and psychological factors involved in the persecution trauma. This appears all the more indicated because, in my opinion, the acquisition of a fuller knowledge constitutes the only way to arrive at a better clinical understanding of the survivors and their problems, and will enable us to help them not only in a legal and juridical sense, but also from the point of view of therapy, rehabilitation, and resocialization.

In this effort to convey to you a more complete knowledge of what really went on and what the persecution trauma consists of, I have endeavored to give you, in these charts, a sort of "bird's-eye view" of the nature of the experience I encountered when I was working on these charts. I had tremendous difficulty myself with formulating and reducing the experience into words, and so I beg your pardon if I succeeded only very incompletely and inadequately in trying to put these things down on paper.

CHART NO. 1

MAIN CHARACTERISTICS OF THE TRAUMA

1. Protracted Life-Endangering Situation in a State of Total Helplessness
2. Chronic Starvation (1200-1400 Calories; Later 600 Calories)
3. Physical Maltreatment with Fear of Total Annihilation
4. Total Degradation to the Point of Dehumanization (Existence is reduced "to something not fully human and yet not quite animal, no longer the adult and yet not quite the child."
R. J. Lifton)
5. Recurrent Terror Episodes (Selections)
6. Total or Almost Total Family Loss
7. Abrogation of Causality
8. Assaults on and Impairment of Identity with Changes of Self-Image; Self-Estrangement
9. Prolonged "Living-Dead" Existence with No Way Out and growing feeling that one's "non-existence is entirely possible" (*Erolson*) leading into



The first chart tries to convey the nature of the trauma, its main characteristics, and what the concentration-camp experience was. If we look at the first three points, we will find mainly the physiological and physical aspects of the experience. Chronic starvation: in the early years, the inmates of the concentration camps received perhaps 1200-1400 calories from some watery soup and some vegetables; later, this was reduced to 600 calories daily, with a full day of forced labor. Labor was 10 to 12 hours a day, and for this reason alone, most of the victims succumbed and went promptly, during a period of a few weeks or months, into a state of starvation and death. This tactic was an effective means of creating a protracted life-endangering situation, in a state of total helplessness. We are all well-acquainted with the physical maltreatment endured by the victims: the blows, the brutality of the guards, and the degrading forms of

abuse. From here on, we see the psychological practices which are both interesting and important to us as psychiatrists, psychiatric case workers, social workers, etc. Total degradation to the point of dehumanization: here we have to remember that it was not a "full animalization" as has been implied by some authors in the sense of actual loss of humanity. It is true except for one proviso—that they were pushed down and reduced to the animal level—but, they remained human beings. That is, their ego-ideal, their feelings of rage and shame in seeing themselves changed into animals remained with them. We forget; we are inclined to gloss over it, consequently satisfying ourselves with the term "reduction to an animal level." Physically, absolutely so; but spiritually, humanely, psychologically, they remained humans and that added to tremendous conflict and can still be recaptured, as Dr. Sterba has shown us in her paper. Through psychoanalytic and therapeutic work with these people, we recapture it today, 20 years later. The other aspects speak for themselves, since Dr. Dorsey very rightfully stressed the point of identity. We also have here the impairment of identity, with

CHART NO. 2

REACTIONS AND DEFENSES

Emotional Detachment Rapidly Progressing to

Depersonalization and Derealization

Denial—"It Cannot Be True!"

Automatization of the Ego with Robotlike Numbness

Regression to Preenatal (sado-masochistic, oral, narcissistic) Levels

Identification with Aggressor

Further Automatization and Regression

Potential Adjustment on this Level (*precarious*)

or

"Living-Dead" Existence

"Walking Corpse" Existence

"Shuffling Corpse" Existence



Musulman Stage
(Stupor, Marasmus)



Death

changes of the self-image and self-estrangement. Changes of the body image were effected by requiring that the inmates be fully shaved, dressing them in prisoners' garb, depriving them of everything human, including their names.

These changes of the body and of the self-image led to severe identity problems. The identity and ego-ideal were systematically assaulted with an aim to destruction. All taboos were violated; impulses of help or compassion had to be thwarted. The S.S. men made a special effort to impress the prisoners with the fact that they were going to end up in the gas chamber and crematorium anyway. Accepting this identification with the dead was really the ultimate end of giving up one's own identity. Most of them experienced a semidepersonalization. They all had to deny the reality of their condition ("it cannot be true") but the denial was different from

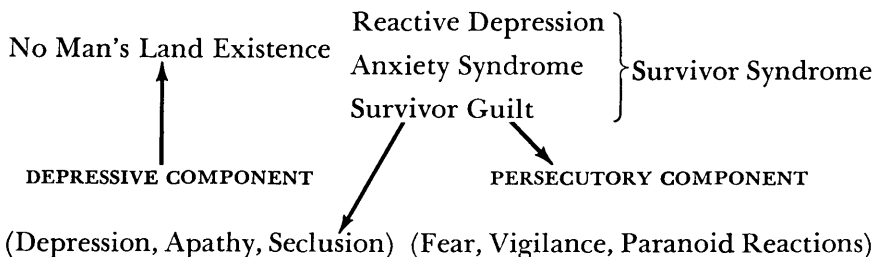
CHART NO. 3

SURVIVAL

A. Immediately after Liberation: Magic Expectancies (Triumph; Reappearance of Lost Family, etc.)

Symptom-free Interval

B. Long-term Aftereffects: Post-traumatic Pathology



Propitiatory and Expiatory Tendencies
 Denial of Aggression with Masochistic Features
 Brooding Absorption in Past and Present Events
 Obsessive-Compulsive Ruminations
 Anxiety Dreams and Nightmares
 Far-reaching Personality Change
 Permanent Feeling of Loss and Sadness
 Partial or Complete Somatization of Complaints

what we see in civilian life; namely, what Dr. Lifton in his *Hiroshima Survivors* has called a psychological closure, more than denial. All feelings ceased to be, at least on the surface, because one could not exist and at the same time live with such feelings of abhorrence, disgust, and terror. Simultaneous with the isolation of affects, there was an automatization of the ego which produced a robotlike numbness, giving the inmates a sordid-looking, emaciated, puppetlike appearance.

This picture was accompanied by regression to a pregenital level with some identification with the aggressor, Capos. Although such a level of survival was not secure it was temporarily workable, and a few could make it in that way. For those who were not able to remain on this precarious level, the process went further. The living-dead existence was transformed into a sort of "walking corpse" existence, then into the "shuffling corpse" existence. Bettelheim (1960) writes that when these emaciated, sordid-looking puppets began to shuffle, the inmates themselves recognized that the next step was in the offing: the musulman stage, the marasmus, psychiatric stupor, turning away from everything—culminating in death.

CHART NO. 4

SURVIVOR SYNDROME (As a Clinical Entity)

Reverberating Terror Experiences



Past Danger is Felt as Present Danger

Chronic Reactive Depression

Character Changes

Survivor Triad: Insomnia

Nightmares

Headaches and Somatic Equivalents

If we understand the massive and contractive stress of this type, then we can perhaps better understand the symptoms and various manifestations we see today among the survivors. For brevity, and also as an attempt at oversimplification (the problem is considerably more complicated), I have summarized the Survivor Syndrome as: a mixture of reactive chronic depression and anxiety syndrome

with ongoing survivor guilt. The survivor guilt as we see it today, and which was mentioned by Dr. Sterba in detail as she has observed it, can be divided into its depressive components and a persecutory component. The guilt is felt as a constant depressive which follows them; it is sometimes a personalized, active force, expressing itself clinically in terms of a constant fear and vigilance, with paranoiac reactions. As a persecutory component, for instance, the patients have to go to the other side of the street when they see a policeman. They cannot walk by a policeman, perceiving him as an enemy who might capture them. The doctor is similarly regarded as an enemy. Even if, consciously, it is made clear to the patient that the examining doctor is there to help him, he feels, unconsciously, in the transference setting, that the doctor is a potential and sometimes actual persecutor. The depressive component makes itself visible in the complete withdrawal, apathy, brooding seclusion, state of depression, and especially the permanent feeling of loss and sadness in these people. Clinically, what is most important is what is called the "symptom-free interval," especially in the medical psychiatric appraisal of these patients for the Compensation Board. Since Dr. Sterba has already given a description of the symptom-free interval, I was especially impressed with how independent observers, from various sources, have arrived at the same findings. If I may quote from one of my former papers: "What is important in most cases, especially from a psychiatric forensic viewpoint, is the existence of a relatively free interval between liberation or later discharge from displaced persons hospitals in Europe and the development of new symptoms after a period of months or years following their arrival in the United States." Thus immediately after liberation, the survivor has a feeling of triumph combined with mounting expectations—"everything will be good," "now we will find our own family," etc. Later on, however, after the symptom-free interval, there are the long-term aftereffects, i.e., the post-traumatic pathology. In legitimate indemnification, claims have been denied because of what the German Compensation Courts call "Brückensymptome"—transition symptoms—the manifestations of which occur during the above-mentioned interval. I have been able to demonstrate to my satisfaction that the symptom-free interval was characteristic of the psychiatric sequelae of persecution, particularly among those victims who were the only or one of a few survivors of

their family, and consequently carried within themselves a double burden of guilt. First, the actual loss and the grief experienced through the impact of the disaster and the extermination of their beloved ones; second, the ever-present feeling of guilt accompanied by conscious and unconscious dread of punishment for having survived the very disaster to which these beloved ones succumbed. In the beginning, the survivors could tell themselves, during the years immediately following liberation, that some of their missing family members might still miraculously reappear. The magic expectations were given up only very gradually and incompletely, with many cases *still* cherishing fantasies of miraculous reunion. Later, they were exposed to the many adjustment difficulties in the initial hardships following their arrival in the United States. They remained relatively free of symptoms and self-punishing tendencies. When, in the end, they had to recognize there was no hope, however magically resorted to, for the return of the lost relatives, and when they finally appeared to be settled and adjusted to their new surroundings, then, at that time, they often break down. This is some type of postpersecution symptomatology, as described in the various features of the symptomatology as we see it today. I wish to name a point for further research, because it does not only refer to these survivors but, perhaps to a lesser degree with some variance, to any survivors of any severe disaster, even in civilian life. In disasters such as ship fires, or other catastrophes, we must draw attention to the need for a better definition of the process of traumatization. What we used to call traumatic neurosis has gradually expanded and has come to include new implications and areas of aftereffects.

I will close by attempting to visualize the impact of severe trauma, including shipwrecks and similar events.

- 1) *The impact of the potentially traumatic perception:* Under this impact, a number of people become numbed, stunned; it is so powerful that many succumb, for instance in a shipwreck, not simply because they have no chance to escape but because of the emotional reaction to the impact. Overwhelming with terror may cause immediate death.
- 2) *Acute reaction stage:* For those who endure it, this is followed by a second stage, which I have indicated here as emotional detachment with confusion, depersonalization, or semidepersonalization. These people become confused and at the same

time try to deny. Indeed, Dillon and others in Philadelphia have examined and described their findings as such, especially from ship disasters; there are similar reactions among them, although with big differences. Let us call it depersonalization, derealization, and denial.

- 3) *Delayed aftereffects*: The post-traumatic pathology which may include an aspect of potential growth. Most will be subject to long-term aftereffects with post-traumatic pathology, depression, anxiety, etc. In certain individuals, whom we cannot define in advance as yet, there might even be further growth (if it is not overwhelming or too massive). Events that might be potentially traumatic to some may, in some circumstances, become utilized in wish fulfillment.

I tried to show two years ago, in my study of Schlieman and his shipwreck, that a new supplementary development is possible. Where post-traumatic pathology develops, we can recognize these three, as well as other elements which I have written up here. The work on the late traumatic sequelae, as manifested by the survivors of persecution, has helped to highlight issues of importance to universal situations of overwhelming traumatization.

NEUROLOGISM AND DENIAL OF PSYCHIC TRAUMA IN EXTERMINATION-CAMP SURVIVORS

JOOST A. M. MEERLOO, M.D.:

This brief note is intended to direct attention to a theoretical conflict within the ranks of the psychiatric profession—one that often leads to tragedy for patients who are caught in the crossfire. The question is: Do we accept the fact of psychic trauma, or do we capitulate to the school of “nothing but” chemical and neurological etiology of inner disturbances?

During the past years I have examined and reexamined several survivors of extermination camps who were nominees for monetary compensation by the West German government for damages suffered during the Hitler regime. As I listened with horror to their tales of years of persecution and torture in prisons and concentration

camps, I was sometimes just as infuriated by the prejudiced course of previous medical examination in deciding on the amount of damage related to the traumatic years.

In several instances an elaborate internal and neurological examination was thought to be sufficient, with full attention given to the eventual results of physical torture. However, no thorough psychiatric interview was considered necessary. Usually, the patient was sent home with some parting remark such as: "I'm sorry, I cannot diagnose any bad result from your concentration-camp sojourn."

The moment these patients, already hypersensitized by their locked-in memories of concentration camps, wanted to unburden themselves of their accumulated nightmares and anxieties, they encountered a cold, defensive wall of silence on the part of the interviewer, which only aroused in them the old bitter feeling that there was no justice to be found in this world.

There are two different reasons for this attitude of denial of psychic trauma. In the first place, psychiatry, like every growing science, has to work with tentative concepts, leading to tragic schisms in thought about the etiology of mental disturbance. Yet the psychoanalytic forms of therapy and psychosomatic medicine in general are enough to yield convincing evidence of psychic etiology. Beyond this theoretical schism, there can be no doubt as to the existence of emotional contagion and mental contamination. Inadvertently, another process forces many an interviewer to deny the existence of psychic trauma and its resulting traumatic neurosis or psychosis. Many times I was told by patients that the interviewing expert talked to them of his own sufferings under the Nazis while shedding crocodile tears. He played, as it were, a dual role: on the one hand he identified with the enemy, whose financial interests he had to defend, but on the other he also had to defend himself against his own inner emotional turmoil by unwittingly taking a sadistic, defensive attitude toward the patient with whom he refused to identify, lest his own self-pity set in again.

Our diversified psychiatric concepts give in easily to our deep-seated private emotional needs. Yet, for many a patient such treatment, combined with the physician's hiding behind the neurological hammer, was a repetition of the old trauma, stirring up new psychosomatic defenses. In one person it brought on an acute heart attack.

In this note I cannot report in detail the typical traumatic change

in some of the extermination-camp survivors. However, many clinicians who do not feel so defensive and dare also to adhere to the theory of psychic and environmental etiology, emphasize a typical group of symptoms representing the psychic scars of concentration-camp victims. Among these symptoms are the repeated nightmare of being sent back to the concentration camp and the gas ovens; the amnesia for the time before the onset of the terror (no early childhood memories); the change in the concept of self as expressed in chronic depression, with continual adaptation difficulties; the relatively healthy interval—the traumatic incubation time—until the encapsulation of the nightmare is opened by a triggering emotional experience (such as seeing the movie about Anne Frank); the continual guilt over not having joined the dead victims of extermination. The last factor explains the continual danger of suicide or its equivalents.

When a psychic trauma has enough impact and lasts long enough it alters the personality. No reflex hammer can help here in our judgment. For us psychiatrists, it is a challenge to stick to our guns and not give way to those who only believe in “nothing but” theories.

DELAYED MOURNING IN VICTIMS OF EXTERMINATION CAMPS

DR. MEERLOO:

In 1945, we had the first opportunity for psychiatric observation of victims of extermination camps. The mood of liberation, the thoughts of new hope, the physical aid that had to be given, the lack of deeper analytic experiences made it impossible for us to initially gauge the deeper pathology caused by the long-lasting wounds of physical and mental torture.

Yet, even in those early days, we already saw the reactive despair in people who had for years lived under immense tension and now found themselves in the new vacuum of “normal” life. It was as if

Paper read for the Special Conference on The Pathologic Effects of the Concentration Camp Experience, Montefiore Hospital, New York, May 31, 1962. Reprinted from *J. Hillside Hosp.*, 12:2, 1963.

sudden abstention psychoses developed, in this case meaning abstention from danger, fear, and hatred. Besides the acute depressions, we found the strangest paranoid delusions, an outcry of pent-up screaming, which usually subsided after a couple of weeks of good physical care. I witnessed a comparable paradoxical reaction in a nearly experimental setting in the town of Dover, England, which for four long years was in the fireline of the German batteries on the Belgian coast. During those years the people were very courageous. They lived in shelters and kept their tensions hidden behind their smiling masks, until one day the Allies swept the Belgian coast and captured the German heavy guns. The shelling of the British coast was ended, but now people became tearful and wept and nearly the whole town of Dover suffered a nervous "flop" because of the sudden loss of self-control over tension. There was no social need anymore to behave well.

Let us not forget that tears and crying, wailing, and loss of self-control were the most dangerous reactions in the concentration camp. Such outbursts would have been reason for the cruel enemy to select the pathetic victim at once for the gas chamber.

As High Commissioner for Welfare for The Netherlands, I had mostly to deal with Dutch victims. Most of the survivors—even when they had lost all their relatives—adapted themselves rather well when they were able to come back to a friendly fatherland. However, in a few people one could see a masochistic pattern coming into action from the very start of their liberation. Every future is denied, any gratification is forsaken, and a withdrawal into persistent unhappiness takes place; they have chosen the pseudosecurity of constant suspicion and hopelessness. There are certain psychic wounds that prevent the utilization of the new-found freedom. These victims continue to live under the enemy's death verdict.

Among all these acute liberation reactions only one basic emotional reaction remained in those I could observe in later years among immigrants mostly of Polish origin, namely, their confusion about the rituals of mourning and their own guilt when the problems of deprivation through death came near to them again. Several patients broke out in acute depression when years later they had to pay homage to friends or acquaintances in mourning.

For the rest of this paper I want to limit myself to a discussion of this repressed mourning reaction.

In mourning ritual and in our homage to the dead, we attempt to cleanse ourselves of earlier hostile wishes toward the deceased person or toward those they may have represented. A bitter philosopher expressed this in a general play on words by saying about the cemetery: "Here lie the dead and here lie the living," meaning that in death ceremonials the truth gets lost. He, however, was not aware of the paradoxical unconscious processes aroused through death, whether of foe or friend. We find this more honestly expressed in St. Matthew: "Let the dead bury the dead. Follow me!"

I was amazed and surprised to hear from people who had gone through the horror of concentration camps that their greatest complaint was that they had not been permitted to mourn over their dead, those they had lost in these very camps. Not the torture, not the famine, not the humiliation kept them down now, but this lack of cathartic ceremonial. In the midst of the hell of death, they, the survivors, felt themselves just as guilty as the Nazi murderers.

One of the hidden thoughts of every inmate had been: "If my neighbor gets killed before I do, I get another chance to live." The former campmates showed guilt and anxiety because their unconscious murderous wishes had been stirred up. I could report to you the strangest and most tragic acts of betrayal between parents and children and brothers and sisters. Many former inmates had from then on to battle against the gnawing feelings of self-reproach because they survived while their loved ones did not.

I have seen several cases of survivors who *had* to go through an outburst of increased mourning and depression years later when some acquaintance or relative died. Through these depressions, which were often suicidal, they tried to purify themselves of past death wishes; now they went through the mourning rituals they were forbidden to perform during the camp years. One of my patients went through a severe depression every time a member of her social circle died.

Even nowadays the dreams of concentration-camp victims are monotonous, repeating some of their guilty fantasies from the past. In their dreams they are continually reliving and ruminating on all the past calamities. The Nazis are coming again and husband or child is dragged forth into a new concentration camp. Though the surface of the dream is full of despair, underneath is the compulsive repetition of an old guilt fantasy. It is an endless repetition

of sadomasochistic fantasies, of a hatred that cannot be given up and that either has to lead to destruction of themselves or others. There is increased danger of suicide because the compulsion is that they have to join those they feel to have betrayed.

The importance of this syndrome of delayed mourning and identification with the murdered victims is that it is repeatedly triggered off by actual incidents such as the loss of friends, a renewed emigration, or the loss of a job, and it suddenly occurs after years of relatively symptom-free existence.

This symptomatology means that there exists an intrinsic relation between the traumatic psychic death during the camp years and the psychotic phase now. An additional proof of this close relation is that most of these patients have a nearly complete amnesia for the time prior to their being sent to a concentration camp. For them, life begins with the years of torture. In most instances, neither psychoanalysis nor hypnoanalysis have been able to lift the amnesia.

A working through of this delayed mourning with the patient and helping him to face his grief and guilt, while even urging him to repeat some of the orthodox cathartic rituals, proved to be advantageous for the psychotherapy of these delayed mourning reactions.

PERMANENT CHARACTER CHANGES AS AN AFTEREFFECT OF PERSECUTION

GUSTAV BYCHOWSKI, M.D.

What I would like to present to you is in the nature of a synthesis of my personal observations. I am sure all of you are familiar with the main literature on the subject, which is growing rapidly, but I have always found through my own experience that it is more interesting to become acquainted with the speaker's personal experience than to hear him discuss the literature. I will refer to some other writings only when I feel it is necessary in order to clarify some of my points. In the last few years, as you have heard, a number of us have had the sad opportunity to study these unhappy victims of the concentration camps and the ghettos. In so doing, we were able to gather many observations, which I would like to share with you.

My presentation deals with permanent alterations of personality. It would seem that this title is redundant insofar as we must fully agree with the statement of one of the German psychiatrists who studied these individuals—in all his material he could find no one who had been able to avoid some permanent damage to his personality.

My own observation will encompass 40 patients, most of whom were referred to me for the purpose of psychiatric opinion by the United Restitution Organization. Some of these patients, but very few, came on their own. In our involvement with them, we frequently had to deal with opinions rendered by our German colleagues, especially colleagues who examined the patients in an official capacity.

I will share with you some of my observations and reflections on what one might call the psychology of certain psychiatrists. You also know, from what you have heard here, that it is not easy to maintain that kind of objectivity necessary for scientific research. You see too much human suffering, too much misery, and you have to exercise a certain will power in order not to be carried away by your emotions. I will try to do that here and remain as objective as is possible.

To begin with let me present a sketchy description of some of the major changes and alterations in personality which we observed. There is no doubt that if one would try to characterize by means of a single word the change of personality which we observed frequently, one would have to describe it as depression. But, as you know, the word depression covers a wide range of phenomena, and there are a variety of nuances and clinical shadings in these depressions. Some of them we will try to apply. Any clinician who has had anything to do with depressions knows that clinically the picture of a depression ranges along a very wide continuum. At one pole we have apathy, indifference, and withdrawal (which psychoanalytically would be called withdrawal of cathexis), at the other there is agitation, movement, and restlessness. We can observe all this in our patients. What we see most frequently, however, is the picture of an apathetic depression of hopelessness and resignation. Theoretically, we all know that even in a quiet apathetic depression, the depressed patient whose remorse is directed primarily against himself and not against others, is harboring a substantial amount of hostility. We may find it in our patients as well, even in those who at first strike

us as hopeless, helpless, and hapless victims of cruelty. They too may express aggression and hostility but they have to be given an opportunity to do so. This is, of course, an important point for the examination. If these patients find themselves facing an official German psychiatrist who doesn't give them this opportunity to express themselves, but frightens them even more, then none of their hostility or their aggression becomes apparent. In most of the cases, it is important to recognize the scars, as far as the past of the patient is concerned, in order to reconstruct a view of his former personality and the changes produced by the persecutions. In a number of cases we can see that the persecution has resulted in a permanent change of personality. We saw a number of individuals who, according to their own testimony, testimony of their friends, of their surviving relatives, and of a physician who had known them in their past, were friendly, outgoing persons who were open toward the world and full of affirmation of life and optimism. They are much different now. The changes are often so startling as to be considerably perturbing for the examiner.

The common picture is that of a depressive syndrome complicated by trends from many other derivations. For the sake of a certain order in presentation, I will divide these trends into three main groups:

- 1) Anxiety and traumatic neurosis.
- 2) Psychosomatic involvement, or what is called in the literature "somatization."
- 3) Primary or secondary organic reaction.

In the excellent charts which Dr. Niederland has prepared, you saw how complex these pictures are. I will limit myself to painting the pictures in larger strokes. Anxiety and anxiety neurosis are the most typical syndromes. They are not confined only to patients where they are the only and predominant features, patients whom we would describe as affected by chronic anxiety and traumatic neurosis. In my experience there were no patients in this group who did not display these symptoms. However, it is important to know that in addition to *prima facie*, direct anxiety which is so easy to see, patients display also what may be called equivalents of anxiety. And, as you know, these equivalents of anxiety function as parts, like the various tones contributed by a number of instruments to the total sound of

a musical piece. When we hear the beginning of the Fifth Symphony, we recognize that well-known motif which may alert us to the anticipation of the entire opus. Similarly among the group of survivors, the anxiety is so repressed that the patient doesn't demonstrate it, although he may show partial physiological responses. He may have cardiac symptoms, or outbreaks of perspiration. There may be moments during which he feels as if he is "losing his mind," or during which he may become confused—these may also be equivalents of anxiety. Or, and this is of special significance from a practical point of view, he may display disturbances of an important function of the ego (as an analyst would call it), such as consciousness. We have the whole gamut—the scale ranging from brief moments of confusion, to disorientation without loss of consciousness, to total loss of consciousness. Such an episode might be diagnosed incorrectly as hysteria. Fainting without demonstrable change in the brain is considered by some to be pathognomonic of hysteria. However, the work done by Wiesner and his co-workers, who experimented with artificially induced fear and terror by showing some frightening scenes and/or by firing a shot, indicated that in many of his subjects who were so-called normal individuals such an extraordinary frightening stimulus would also often result in either a temporary cessation of consciousness or a temporary fragmentation of the ego. If this were possible in an experimental setup, under otherwise normal circumstances, with a frightening stimulus which would last for a fraction of a second, then you can easily imagine that a continuation of terror and danger to survival for several years could not leave such an important function of the ego as consciousness completely unscathed. Another classical symptom of this traumatic neurosis is the hypersensitivity to various noises and stimuli which, along the pattern of conditioned reflex, brings back to the patient's memory some of the horror he had experienced.

When some of these patients hear a knock on the door, this seems to them a dangerous portent. When they see a black limousine coming up and stopping before the door, this evokes terror. When they see a man in uniform, they respond with panic because all this brings back memories of past horrors. These are classical symptoms of traumatic neurosis. The psychoanalytic theory of these conditions is that the ego of the individual was never able to come to terms with the flooding of stimuli by which it had been invaded. Thus, in the

dream where the controls are substantially lessened, the traumatic events are reexperienced. The patient sees himself transported back into the situation of the concentration camp. A mother who is fortunate enough in having escaped the horrors and in having remarried, now has two small children; she may again in the dream see the S.S. men approach her to snatch these two children away from her, just as the others had been snatched in reality.

Then we may have a whole complex of symptoms which point out that there has been some organic damage in the central nervous system. We tend to repeatedly err in seeking only the very tangible, the very gross changes. Obviously if you find a Babinski reflex and other gross abnormal neurological or encephalographic findings, or x-ray evidence of skull fracture, the damage is obvious. German neurologists and psychiatrists in the Thirties have introduced an interesting concept, which I used in my own writings back in Europe: the concept of encephalosis. In distinction from encephalopathy or encephalitis, encephalosis means fine damage to the brain substance which shows not only in psychological symptoms but in some fine neurological symptoms such as certain changes in the reflexes, as well as vegetative dystonia, meaning a state of imbalance—disturbance of the vegetative (i.e., autonomic) nervous system. Another frequent finding is excessive excitability of the muscle system or increased muscle tension. We see this in individuals whose histories indicate numerous beatings on the head with clubs or with other weapons. Even if they got away without any gross skull fracture or electroencephalographic change, it is difficult to assume that there was no organic damage of the brain substance. The fact that in addition the same patients showed neurotic symptomatology does not rule out the organic damage. Indeed, it would be a very naïve way of clinical thinking to say that it is always either/or—that it is always psychogenic or organic. I remember that my revered teacher, Eugen Bleuler, prefaced his opinion with: “Don’t ask whether this is psychogenic or organic, instead ask how much of each!” He applied this attitude to every psychiatric examination. If we have this kind of damage to the central nervous system, or some more tangible changes which can be shown by an objective examination, then it should not be at all surprising to find support for organic symptomatology added to the basic picture of depression, just as a painter might add a background and on part of the background add some

figures of a still life. Here we see that the patient who is depressed, perhaps apathetically depressed, in addition shows subtle or not so subtle changes in orientation, in memory, in memorizing, in remembering temporal sequences, etc. Thus we can have functional disturbances even where there is organicity as well. We have a number of patients where this primary organicity was much more definite because they suffered, let us say, from epilepsy. But we also have secondary organicity which, for the clinician, is of great importance, and it is especially important to this problem of legal opinion when we have to explain it to the courts or to the German authorities.

We become particularly confused when we expect to find the picture of traumatic neurosis as described around World War I. Here, we are dealing with multiple traumatization, stresses of all kinds, and with an entirely different kind of long-term damage. Our more complete knowledge has expanded the total picture to include such symptoms as: listlessness, lack of attention, disturbances of concentration, agitation, temporary memory trouble, panic, etc. We see individuals with healthy psychophysical constitutions and good former background and history, develop at much too early an age symptoms of hypertension, arteriosclerosis, and premature senility. Our colleagues inadequately acquainted with these problems may say, "Well, between the ages of 55 and 60 everybody may become senile. It is not unusual." But, if we see a person with a healthy family history and generally excellent background develop evident memory disturbance, it is not unlikely that this condition may be a direct result of persecution. I would postulate that the extreme stress lasting for years has resulted in this premature senility, premature arteriosclerosis, or even some changes in cardiac function; *secondarily* this affects the cerebral substance, which is the most vulnerable tissue we have. These are some characteristic clinical pictures. We see an individual who is depressed, but we are also dealing with a person whose memory is faulty, whose orientation is defective, who is afraid not only of the ghosts of the past which may haunt him or her on every street, at every time of the day—but especially at dusk, twilight, or night. Similarly, we may see a person who is bewildered and displays symptoms or affects which perhaps would be most adequately covered by the term perplexity: "I am lost. Where am I? What am I? What am I doing here?"

I was recently able to acquire a painting by a young European

painter who must have gone through the persecutions himself. He paints a picture of his mother who arrived, after all her tribulations, in Paris. She is standing on one of the Paris boulevards supposedly waiting for a reunion with her son. She stands there isolated, though spatially close to the rest of us. She is perplexed.

Then we see couples who can not come to the office singly. They have to come together. When one observes them protecting and supporting each other so that they shouldn't get lost in the "jungle of Manhattan," one is reminded of the parable of "the lame leading the blind."

Among the phenomenological shadings of the depression, one should mention apathetic indifference, estrangement, and blunting of affects. It is quite important for us to realize that this depends to a large extent on the age at which the individual became affected by the persecution. It is significant that the most deeply affected may be the person who was subjected to this Golgotha when he or she was a child. As a consequence of the experience, certain symptoms develop which Minkowski referred to as "Emotional Anesthesia," and where there is very little object cathexis. In trying to work with such people, one gets the feeling that a wall remains between you, just as very often the wall remains between you and a schizophrenic you would like to help. I do not mean to imply that these people are schizophrenic—they are not—but there is something fundamentally wrong with them. I have had a couple of such very moving experiences where I made a personal investment. I tried to befriend a very young man who started his road through the camps when he was five years old and had escaped. He was protected; he came out; he emigrated to the U.S.A. and very courageously and brilliantly made his way in New York—unfortunately his affective life is dulled. No matter what I do for him, he says thank you without any genuine affect or indication of an intimate relationship. Intellectually he has developed beautifully; he graduated with flying colors and is doing well in his profession. However, the question is: are we friends? He thinks we are—but thank God, I have better friends than that. If we now try to approach the structure of this depression, applying the existential point of view, we see a picture characterized by the destruction of his world, the destruction of the basic landmarks on which the world of human beings in our civilization is based, i.e., basic trust in human worth, basic confidence, basic hope.

Here there is no trust, there is no confidence, everything has been shattered to pieces. I was very moved when I realized that we have other sources of observation which parallel this. The studies of brainwashing on Korean prisoners-of-war, and also on people who were held for many years in Communist Chinese prisons revealed personality changes resembling the ones I described. In studying the Hiroshima survivors, Dr. R. J. Lifton observed this same phenomenon of destruction of the basic confidence in the structure of the world in which we live and on which we base our life.

For the first time in the history of mankind a people has been treated not like human beings but like vermin, fit only for extermination. Often, women were asked to lie down in the mud so that the S.S. men could walk over their bodies, living bodies, in order not to dirty their polished boots. These people were trampled upon literally, until their self-respect was destroyed, an important etiological factor in the development of a depressive syndrome. When one considers the total picture, another essential feature of a depression fits the situation: that is, the reaction of mourning. In the normal course of a mourning reaction, a person deals with one loss at a time, which makes possible the completion, the working through of grief. However, the survivors of the camps were never able to satisfactorily accomplish the work of mourning, because there was no world to which they could return. Their villages, their homes and ways of life had all been destroyed. Large families, whole clans were killed. Insofar as there was nothing for them to go back to, there was very little basis for rebuilding what we call a world of objects. For this very reason, the normal mourning period has never been completely worked through. The failure to work through the loss causes their cathexes to remain attached to the lost objects, as a result of which their lives are experienced as empty and totally lonely. Even those who were welcomed by relatives and given some vocational rehabilitation, training or retraining, continued to feel lonely and isolated. I remember one of these women who was able to remarry and who still said:

I feel dead, and I feel so ashamed because my husband does everything for me, but I feel dead inside. Sometimes I feel all I would like to do is to walk, walk, march and march until I come to the sea which surrounds this beautiful America, so that I could disappear there.

Because on this great continent, I am all alone and I am not even alone with God because it is difficult for me to believe.

There seems to be a fixation on the process of grieving and the feeling of sadness and desolation, as well as yearning for an "oceanic" reunion with the lost but not renounced infantile objects of primary love.

Another conspicuous problem is the aggressiveness which comes through in many ways. It may become a direct hostility. A patient given to crying spells may break down in tears under various apparently neutral conditions, and always when we talk about his past, but otherwise remain very calm. However, if the crying goes on, he will erupt in rage. One might have the impression that he behaves like an enraged catatonic or epileptic who is ready to destroy everything around, such is the pressure of the suppressed rage: it is of fantastic intensity and is totally repressed. He may have a lovely wife and children and be much too ashamed to admit he cannot do justice to his family. Such a man might return from work and be greeted by his two small children with: "Daddy, why can't you play with us? Why can't you talk to us? Other children play with their fathers. They can talk to their fathers and tell them what happened to them that day at school." On this he comments: "I am ashamed, but when I go home all I would like is to be alone in a dark room. I don't like to see them, I don't like to hear them."

Dramatic scenes ensue when a woman arrives at the doctor's office with her husband and proceeds to complain about the latter's behavior. She demands from the physician, "You must do something so that he will change toward me, otherwise I will divorce him. I cannot stand it." And the husband says, "Go ahead, all I want is to be left alone." And yet, if you analyze him, he has nothing to blame her for. Studies which have been done on victims of oppression confirm or parallel some of these findings. T. Grygier, a Polish social scientist, now a professor in Toronto, has studied these problems, while he himself was deported by the Russians to a labor camp within the Arctic Circle. After the war he studied the Polish displaced persons, and described the psychological immediate picture upon liberation. In his careful report entitled "A Study of Oppression," he described many of the features which we see here: aggressiveness, rigidity, withdrawal, lack of pliability, etc.

We see patients disturbed not only in the affective sphere, but where the healing function of the ego has suffered serious damage. They are drifting along; they cannot find a goal for themselves. Some have the potential to make outstanding successes for themselves, but find themselves incapable of taking action. I saw a young woman who was able to go through professional training when she came to the States; she was able to marry; her mother was safe; she had a child; and yet, the feeling of being lost, the feeling of drifting, and the lack of direction was such that despite all the possible help we were trying to give her, she committed suicide.

Conspicuous among the problems of the survivor are the guilt feelings, "*Why am I the one who survived?*" As we well know, the guilt feeling is always a classic feature of every depression. Survivor guilt is verbalized in these themes: "Why didn't I save them? Why was I saved myself? They were better than me." I had a few depressed patients in New York who, after the assassination of President Kennedy, had conscious suicidal impulses with the idea that they should have been killed instead of this great man whom the nation needed. Thus, in transference, they reexperienced their survivor guilt. Such reactions are well known to American psychiatry from the observations during the war. Kubie and other authors described American sailors who had survived being torpedoed by German U-boats. These people developed serious depression and the feeling of guilt: "My buddy was a much better man; he should have been saved rather than me."

Among the survivors, one can find individuals who behave as though they have developed a psychopathy. Those are the rare cases of an acquired psychopathy and we have been able to reconstruct the dramatic personality changes in such individuals. One of these cases was a man from the large Polish city of Bialystok who, in the ghetto, was forced to do some work for an S.S. man. He was then approached by another S.S. man who commanded him to perform a different task. The first S.S. man returned and became enraged that the man was "disobeying him." He attacked him with a window frame and the glass shattered on his head and face. To this day the man's face is distorted because of the hundreds of small fragments of glass which were embedded in it. Despite a number of operations, the face could not be changed. This disfigurement creates in him a feeling of inferiority. He feels that people must look upon him as though he

was a member of the underworld. He cannot find a good job; he has to hide, etc. His appearance has caused a serious personality change. However, a German colleague practicing in New York, who reviewed the case for the German Court, felt that, in his opinion, no one could have feelings of inferiority because he has some scars on his face. Said the doctor, "I have a (fencing) scar also and I feel very happy, and I am even a professor." Conclusion: Since this man with his scar feels so unhappy, he must have a constitutional inferiority. The callousness and lack of empathy are astounding.

The problems of aggression in the survivors are related to the mechanism of identification with the aggressor. Under these circumstances, one can develop hostility to one's fellow victims. Such individuals have been unable to undo this identification, and now find themselves isolated from their present environment. The price of survival through identification with the aggressor is a serious characterological derangement, corruption of the superego, or tendency to severe depression. Ringelblum, the historian of the Warsaw Ghetto, was not familiar with the concept of "identification with the aggressor," but he described to what extent some of these people, who had to hide in the cellars and other hideouts, time and again identified with the enemy in both their fantasies and behavior.

Now, do we find "real" psychoses? This matter has been long debated. Some people say that manic-depressive psychosis and schizophrenia must be the result of constitutional predisposition (*Anlage*). It is fascinating to see that while German courts and legislature will not deny the fact that schizophrenia may be based, among other things, on some constitutional elements of which we know practically nothing, but which were proven by very careful studies of heredity, they still admit that very special conditions bring about a schizophreniclike picture which would not have developed without this special stress. There are very few such cases, but some of them exist. There are also cases which were wrongly diagnosed by our German colleagues, as a basis for denying compensation. We are presented with a young woman of whom it is said that she is a paranoid schizophrenic. If she is a paranoid schizophrenic, there must be *Anlage*—this is inborn, therefore no compensation. This woman saw everybody in her family killed before her eyes, completely wiped out. A little sister, whom she took care of when their mother was killed, was snatched away from her and smashed against

a wall before her very eyes. Has this nothing to do with the fact that she is a schizophrenic? The irony in this case was that when I examined her, I found her not to be schizophrenic at all. What are her symptoms? She thinks that people on the street look at her with pity. She is so miserable that she projects her own pity on the passers-by. She has hallucinations. What hallucinations? Well, sometimes in the street she is *sure* that she sees somebody from the camp; that her dead brother came back or that one of the worst persecutors from the camp (one of the guards) is after her (mind you, on a New York street) but she looks back and says, "No, this is just a fantasy." This is not a hallucination, just as the other was not a delusion. To describe this theoretically: some of the objects, both of love and of hatred, which her ego incorporated in the past—these introjects, which have never been completely integrated into her personality, behave like "foreign invaders." They come back and haunt her—the "bad people," the S.S. men, the guards, the Capos, or the "good people," the people she loves. Yet, she is able to make the difference, to see the differences between fantasy and reality. Were she a schizophrenic, would not the causes of her emotional problems have been different? Essentially, we see individuals who underwent the impact of extraordinary moral and physical stress. We don't emphasize the physical stress because this is self-evident: dreadful starvation, exposure, beatings, and difficulties in satisfying the most elementary needs. Some were allowed to go to the bathroom only on rare occasions, and were subjected to various sadistic tortures in which the S.S. men excelled; many suffered infectious diseases such as typhoid, typhus, various dysenteries, pneumonia, and others.

In summary, it is natural that in these people with all this fantastic stress—the loneliness, the isolation, the loss of the world of love, of all objects which are indispensable to normal living—serious permanent changes in personalities resulted. All of these people walk around like human wrecks, like ghosts. The fact that some of them are able to make a fair adjustment, owing to various help, and some of them even have enough courage to try to rebuild their life in our generous country is most heartwarming and most extraordinary. With the concentration-camp survivors, the logical question is not "Why are people so sick?" but "How come so many of them have still preserved some sanity?"

GENERAL DISCUSSION OF THE WORKSHOP THEMES

DR. KRYSTAL

The consideration of the nature and contents of delusions of survivors brings to mind one case which I saw recently. The patient told me that he was 3,000 years old, that he had three wives, and that with each one of them he had two boys and a girl—all his own age. He believes that every day he goes up to the seventh heaven where he has seven officers to assist him, and there he makes a "selection" of 1,080 people. The word "selection" made him frightened because it represented a breakthrough of his aggression. As Drs. Niederland and Bychowski point out, this has to do with the denial of identification with the aggressor. In an attempt to undo his aggression, he explained that when the people were "selected" by the Nazis in the camps or in the ghetto they were sent to America—so his parents are somewhere in America. The denial is of psychotic proportion. The hospital diagnosis was paranoid schizophrenia, but the contents and the defenses, as you see, are very pertinent to the patient's attempt to deal with his loss of relatives, with his aggression, and problems of identification. In studies of traumatized people we must look for their defenses and reactions, and must specifically identify their fate before we can evaluate the aftereffects.

Many of the concentration-camp survivors are not able to relate or to report some of the manners of assault, especially sexual assault. Both men and women were assaulted. Many women were raped and are reluctant to admit to it; sometimes we have to learn of it by secondary evidence. Besides the guilt problem, we have to be aware of problems of shame which make it impossible for the patients to relate or even to be conscious of the history of their degradation. Some people are afraid to admit to rape because, according to the opinion of a significant number of "experts," such history automatically makes them a psychopathic character. One woman, who at the age of 18 was raped by an S.S. man in Auschwitz, was diagnosed "a prostitute and a psychopathic character." There is hence some justification to the fears that survivors have in relating their experiences in view of the special reaction many people have to survivors—namely, that of suspicion.

RICHARD STERBA, M.D.:

I am very deeply impressed, in a two-fold way: first, by the immense human misery which has been demonstrated; and secondly, by the difficulties in trying to look at it objectively. Such studies are so difficult, that they must require a long period of self-training in order not to become involved emotionally in one countertransference or another, and in the outcries of indignation of such mistreatment of human beings. I would like to express my admiration for the people who can do this work, and am afraid that their number will always be very small.

MRS. REGINA FEUER:

I would like to ask a question concerning a woman who had marriage and sexual troubles with her husband, and who had been raped in the concentration camp. Would you say that she had the *Anlage* before, or that she was fixated in some stage of development and therefore had all those symptoms later?

DR. NIEDERLAND:

This is a question which I can discuss because I had a similar case in treatment. As we found out at our third interview, and only after she had gone through six psychiatric opinions with the diagnosis of serious schizophrenic psychopathy, borderline character problem, etc., she had submitted to intercourse. She was taken to the barracks of the S.S. and had submitted to intercourse in order to preserve her life. The young S.S. Sharfeurer apparently fell in love with her, or was attracted to this very young student nurse of 21 or 22 at the time. She still looked quite good when I saw her 20 years later, quite attractive. This woman had submitted to intercourse repeatedly, in the shadow of the crematorium, in order to save her life—and her life had been saved. She wouldn't talk about it; guilt and other obvious factors were present. However, to come back to your question, at one point or another she was asked why she survived. She would say a word or would not say anything. The colleague wrote down: "She lies, she is not clear. She gives evasive answers when it comes to sexual questions and giving information about her sex life. This indicates that she must have a psychopathic

personality, and this indicates the *Anlage* psychopathy—the *Anlage* in the constitution—therefore, no persecution connection—therefore, no compensation.”

She even accepted that judgment to some extent. This is a woman who saved her own life while siblings, parents, etc., succumbed to the catastrophe. Under the impact of the survivor guilt, she accepted this pronouncement. However, some friends of hers, who were also survivors in the Altro Workshops, told her that she should go to the higher court. She engaged a lawyer, who took her case on a one-year basis, went through the hierarchies of the various courts, and right now the case is with the Supreme Court still awaiting the rendering of a final judgment.

DR. BYCHOWSKI:

This case vignette poses an essential question. If you see a human being who was exposed to such indignities and went through this and saved her life, we have to ask ourselves, “Wouldn’t it be much more abnormal if she spoke of it freely, as though nothing happened?” So she isolated it. To my mind, the fact that she doesn’t want to talk about it is a very normal reaction. She has conscience; she suffers from shame and guilt—not at all like a psychopath.

DR. R. STERBA:

Dr. Niederland, I think we would all be interested in knowing what success you have with the German Courts, in your opinion. After all, they have made such an effort; there is so much scientific material. How do the German authorities react to it?

DR. NIEDERLAND:

This is a very difficult question to answer because it depends on many nonmedical, nonpsychiatric circumstances. However, in connection with our work here in Detroit a year and a half ago through the present, as well as the work in New York, and the various papers which have been published, by and large one can say that in the last year or so things have somewhat improved. There were experts, not only in Germany but in New York City and other places in this country, who were in contact with either involutional or endogenous depressives or neurotics of various kinds, and diagnosed

them usually as *Anlage*-produced psychoneurotic reactions. I am glad to report this has stopped. Now, much more attention is paid to the actual traumatization. The past practice of glossing over the traumatization has been improved upon. Now, the traumatization—what really happened to these people, how they were treated, what they had to go through—is described in more detail. I am also glad to say something here which, although a stain on our profession, has to be said in a gratifying way. There are judges in Germany who receive a psychiatric opinion, even today, from the United States, where a case is diagnosed as involutional depression or as a psychoneurotic reaction due to the *Anlage* (rarely does it happen), and the judge sends it back to one of us and says, “This cannot be true because this man was six years in Auschwitz, the only survivor of a family of so many people, and was subject to such mistreatment. I want an expert to tell me what happened to him as a result of these traumata.” Dr. K. R. Eissler’s paper in *Psyche* (Stuttgart) was very useful in the education of lawyers and other disciplines concerned with these problems.

DR. ARTHUR FEUER:

I would like to direct a question to Dr. Niederland. My question concerns the appearance of symptoms many years after liberation, and when I say that, I mean the documented appearance of symptoms in the medical statements of doctors who have treated the applicants. Now this is peculiar, but there is a concept of German restitution medicine where certain rules and concepts apply *only* to the evaluation of damage to health within the value of restitution. Has it been accepted by German restitution medicine that a “survivor syndrome” can appear years after liberation, or is it still necessary to demonstrate an uninterrupted continuity of symptoms since liberation?

DR. NIEDERLAND:

Yes, it has been accepted, although this was not the case until a year or two ago. Perhaps our first workshop in Detroit was also of a pioneering nature. It was impossible to get a case accepted as persecution-connected where there was a symptom-free interval such as Dr. Sterba spoke of this morning, and which I supplemented

later on. The courts demanded the demonstration of "bridge symptoms," and where there was a symptom-free interval when the patient was found healthy after liberation and remained relatively healthy without serious symptoms during the next three or four years and developed the symptoms only later, it was almost *impossible* to establish an ironclad persecution-connected case for the compensation courts. All these cases were rejected. However, in the last year or year and a half, this has changed. I want to call attention to a German publication which came out just a couple of months ago (late in 1963): *Personalitaets Wechsel nach politischer Verfolgung* by Dr. Helmut Paul and Dr. Hans Jochim Herberg. There is a chapter by these two German authors on the symptom-free interval of which I spoke this morning, and which was originally discussed here.

There is also a chapter on the symptom-free interval in the book, *Psychische Spätschaden nach politischer Verfolgung*.¹ This latest and authoritative German text has an important chapter on this subject and contains the opinions of a number of experts.

DR. BYCHOWSKI:

I would also like to comment on this. It has been most gratifying, as Dr. Niederland has said, to expand our understanding and develop a mode of communication and cooperation with our colleagues abroad. Of course, this takes time. As far as your question is concerned, it is a beautiful example of the general fact that psychiatry is the most humanitarian of sciences, and that we are the pioneers, the bulwark against a great deal of prejudice. For instance, some psychiatrists thought that a reactive depression, which by definition is a reaction, should stop once the provoking cause of it had passed. The idea was of the conventional form: a woman loses her husband; if she is a good wife, she mourns; she remarries; then everything is fine. But, of course, the situation is radically different when the mate and children have been murdered; home, country, religion and God destroyed; and when the patient's survival has been affirmed only after the most fantastic mistreatment, degradation, starvation, and having come so close to dying that she is forever marked with the "touch of death." These people don't show any tendency to

¹ Bibliotheca "Vita Humana" Fasc. 2, published by Swiss House S. Karger, 1963.

exaggerate or to simulate; on the contrary, when they were first seen by the doctor, either because this was still the latency period or because they were so intimidated by the way he examined them, none of the symptoms appeared. If they had been real malingerers or compensation people, they would have exaggerated the symptoms. We find that some of the survivors cannot verbalize their symptoms or problems, and we must help them to do so. This is why psychiatrists are humanitarians.

DR. TANAY:

The possibility of a symptom-free interval is valid, but in my experience this was a period of *denial of illness*, with denial or a displacement of the symptoms. The symptoms were there all the time—they were simply never admitted by the patient. For example, a man was sent to me just a few days ago by a lawyer who specializes in this field. He said, "This particular man has a tremor and has been treating it for ten years. The doctor encloses a certificate about this treatment for ten years. Would you also see him?" At first I said, "You have the wrong person. I'm not a neurologist." But then I agreed to see him. When I saw the man who had been treated for ten years for a "tremor," it turned out that the tremor was almost insignificant. Here was a man who had endured fantastic experiences, exhibiting all the symptoms listed by Dr. Niederland. Just observing him, it was unbelievable that a lawyer or a physician could have managed to miss such gross emotional disturbance. One cannot but wonder at what interfered with their ability to recognize it. In this case, the doctor identified with the patient, treated him for free, and because of his identification with the patient, participated in the act of denial—not recognizing the psychiatric symptomatology.

So, in actuality, there was frequently no such thing as a symptom-free interval; there was a denial of the symptoms on the part of the patient. When I asked the patient, "Why didn't you see a psychiatrist before?" he answered, "No doctor ever mentioned that I should see a psychiatrist." And another interesting comment by that particular man was, "You know, if you go to a doctor and you complain about your stomach, he doesn't listen to you, he treats the stomach." In this particular case, there was no symptom-free interval, but rather a denial of mental trauma and emotional problems.

DR. FEUER:

Actually, it is a problem. Survivor symptoms are not described in the papers and the papers are extremely important to me because, to a large extent, I have to base my opinion on what is written in the reports. We must not forget that the reviewer in Germany does not have the patient before him, he has only the medical reports—"papers." It is this that makes our reports so important.

I was very much interested in what Dr. Bychowski said about encephalosis, and I have made a note that this would be a traumatic vegetative dystonia. In other words, you mentioned, if I understood correctly, that if a person were subjected to maltreatment, to beatings, to repeated bangings on the head, this would be an etiological factor in something that you called encephalosis, causing a traumatic vegetative dystonia.

DR. BYCHOWSKI:

Yes, a traumatic vegetative dystonia would be only one of the accompanying symptoms which is frequently emphasized. If you want literature, this syndrome was first described in the Thirties in Germany, especially in the journal *Der Nervenarzt*.

DR. KRYSTAL:

Also the Danish and Norwegian workers, Eitinger and his group, have done a lot of work which suggests that there is some brain damage, increase in the size of the brain ventricles assumed to be secondary to brain damage due to starvation, with diffuse brain damage.

DR. BYCHOWSKI:

We cannot always prove this condition exists by neurological methods, but it may become clear in the psychiatric examination.

DR. KRYSTAL:

The Norwegian workers believe they have been able to correlate this kind of brain damage with a loss of more than 50 per cent of the body weight. When this occurred, the brain tissue itself was also injured.

DR. NIEDERLAND:

The workers in France, Holland, Norway, Denmark, and Belgium and other countries have long used the term "Post-Concentration-Camp Syndrome" or "Concentration-Camp Syndrome." About a year or two ago I began to use the term "Survivor Syndrome" as a clinical entity, however, giving the full symptomatology and the connection of the traumatic factors with the symptomatology. When this is done, properly, I am also glad to report that the compensation courts look at it with favor or disfavor according to the details of the case. They consider this as a well-documented and tenable and even important diagnostic step.

DR. BYCHOWSKI:

Professor von Baeyer, of Heidelberg, speaks of "Erlebnisereactive Störungen und Ihre Bedeutung—für die Begutachtung" (alteration of personality caused by experiences). What the experiences are, I think, is clear.

MICHAEL KAPRIELIAN, M.D.:

Dr. Bychowski spoke about the "schizophrenic" woman who turned out not to be really schizophrenic, which reminded me of a case of mine which bore certain similarities but perhaps some differences too. In the hospital this woman had been diagnosed as schizophrenic. She had widespread delusions. But when the case was reviewed, we found it had all started when the patient had to project some of her aggression onto the doctors who were going to operate on her four-year-old daughter's urethra; it was from this projection, reaction-formation, and displacement that she formed a delusion. She formed other delusions only when she was confronted with this one delusion, so that by the time she came to the hospital she had rather widespread ideas of reference. I wonder if, in some of your cases, you may have had a case in which the delusions seemed to involve many areas but really originated from one experience or one great stress. You mentioned that all the patient's feelings that policemen were dangerous and that people looked at her referred to the specific experience. Do you have other cases in

which the delusion spreads to other areas that were not directly involved?

DR. KRYSTAL:

That does happen, as if a person became overwhelmed with a feeling, especially anger. It is not rare in the "survivor syndrome" to see people fully sane during the day, but psychotic every single night. One woman has delusions and hallucinations every night that the S.S. men and the dogs are outside her window. As far as she is concerned, her main problem is that her husband does not believe her reports. She wants him to go out every night and get rid of the S.S. men and the dogs. These perceptions are the equivalents of nightmares, and often brought on by dreams. Around this projection, the patient has to build up other ideas to fortify this very real (to her) experience at night. Since the husband did not believe her and would go back to sleep, she would wander around the house all night long. Her inability to get any help to combat the terrible "noises" resulted in a complete loss of hearing which was diagnosed as psychogenic deafness. However, when I saw her and addressed her as if she were a child, she could hear me quite well, with an instantaneous formation of a tenuous transference.

MR. JACK STATTMANN:

I would like to offer an observation from the legal point as one who is handling some of these cases. A number of things have not been clear in my own mind as to the question of "survivor guilt." I have had people in my office, and I have been involved in this kind of work for 25 years, who came in to file a claim against the German government. When one talks to these clients, they start giving you the facts. Then, suddenly you ask, "Were you in this and this camp? Was there anybody else of your family?" Typically, there was a long story, but when that question was broached, the person changed entirely. It was at this point that I would notice the aggressiveness—"Why do I have to answer all these questions? What do you want of me?" Not being a psychiatrist, I would say to them: "You came to me to file a claim." What I want to bring out is that I think a great deal of misery is caused by this guilt. The clients respond with anger and resentment to our re-

quest to retell their story. A man came to me who was told he could file a claim for imprisonment. "Were you in a concentration camp?" "No, my family was." "Who was the family?" "My wife and five children." "What happened to your wife and five children?" "They were all killed." Then I asked him to give me some more facts. "Well, I went on alone because my wife and others told me that nothing will happen to women and children in Germany. That was in 1936, so I went on to England to prepare everything to bring them back over to London. In the meantime, they were deported and all killed." Then he said, "Why were they killed? What am I doing here? I don't want to file a claim." He yelled and cried loudly. He said, "I don't want a claim. Why didn't I bring them to England? What can they pay me for a child? My children would now be 20-25 years old." Then he said, "Whatever I get for this I will give to charity." I had to piece this man's story together from other sources. First of all, because he lost his family he was guilty—he should have done more; secondly, if he didn't do more, why did he save himself?

MRS. FEUER:

In regard to survivor guilt, I have come across many people who are survivors who did not claim compensation. Their interpretation was, "if I don't get the money, the Germans will feel more guilty." Many of them say so.

SANDER J. BREINER, M.D.:

Dr. Niederland has commented upon the degree of dehumanization that occurred, stating that it was so intense in quantity as to constitute a qualitative change. I think an important factor has appeared in all the reports—the *time* in Auschwitz and the *time* in Bergen-Belsen. Maybe what we have here is the *duration* of the insult to the ego having a meaning different from the quantity, in terms of a given moment. There is evidence that the individual who receives a tremendous amount of trauma in a relatively short period of time (weeks or months at the most) generally recovers; but over a long period of time, we see a regression to a very primitive developmental phase. In a sense, these individuals are reliving their childhoods, but now, a very sick childhood—the type of childhood

that would produce a psychosis if it were originally experienced chronologically. Thus, the experience effected a reality-forced regression, not in the service of the ego organization but in the service of survival. Perhaps this model will help us to more fully understand the childhood of adults who are in our state hospitals.

KENNETH PITTS, M.D.:

There have been several comments made about symptoms which were either borderline or appeared to be schizophrenic and which turned out not to be so. I wonder if, in the experiences of you gentlemen, you have had cases in which you found symptoms that you felt were *bona fide* schizophrenic symptoms, which most people would agree upon, in persons who experienced massive concentration-camp trauma and who did not have profound constitutional elements, *Anlage*, or pre-existing ego defects of a serious nature?

DR. BYCHOWSKI:

I personally have not had these observations, but some of our staff in New York have, one of whom is Dr. Max Schur. Such cases have been cited in the literature and they all tie up with our experiences. I am a Bleuler student and as much as Bleuler believed in constitutional syndromes in schizophrenia, he always pointed out that this is rather a group of clinical pictures of syndromes. As you know, his original book was not called *Schizophrenia* but *The Schizophrenias*. He showed us that there were a number of situations and cases where we could definitely trace the schizophrenic symptomatology to certain external causes. There was, for instance, in Zurich in 1918-1919, the famous Spanish Grippe such as occurred in this country, which took the lives of many people. But we also had, in the famous Burghölzli Hospital, where Bleuler was director and professor, a number of patients who, without any special hereditary psychopathological backgrounds, developed during the course of this severe form of influenza such disturbances as finally resulted in a picture which could not be distinguished from schizophrenia. I remember that one of our colleagues wrote a dissertation on this subject. He also had a number of patients who, under the impact of organic brain damage, developed paranoid pictures which could not be distinguished from schizophrenia. Thus, I think this whole

idea that there must be a constitutional predisposition is certainly obsolete; it has to be amended.

DR. TANAY:

Would you say that we see less psychotic manifestation than we have a right to expect? In other words, I have the impression that there is a remarkable lack of psychotic pictures.

DR. KRYSTAL:

I don't think so. The people that we work with, selectively, are the people who are able to come to the office. But lately I have been making visits to the state hospitals and I find a surprising number of patients there who are survivors. I think that these people with predispositions to schizophrenia who developed any serious symptomatology in the camps were killed, therefore, "weeded out." But there were also so many pathogenic forces involved; for instance, migration alone was found to be capable of precipitating a psychosis.

QUESTION:

What happens to these people who get compensation? They receive money because their sisters and brothers, etc. were killed. I would think that this would increase their guilt, increase their depression, and perhaps make an adjustment more difficult.

DR. BYCHOWSKI:

In the first place, I don't think your statement is exactly accurate. These individuals don't get compensation *because* the others were killed. This little word "because" represents the key to a fantasy of guilt for survival.

QUESTIONER:

Still, many people do subjectively react as if they get a pension "for" their lost children.

DR. BYCHOWSKI:

This may be an unconscious implication. They may feel, "Why am I here? Why do I make a life for myself in New York, marry,

have a nice husband, when my sisters got killed?" This kind of thinking reinforces the tragedy and prevents them from enjoying the fruits of new life in our young, generous country. However, the compensation doesn't create the guilt feelings; on the contrary, I saw many who did not so much want the money for itself as they did as a sign of recognition of the wrongs which were done. In fact, it took them a very long time before deciding to visit the psychiatrist. They wanted some modicum of justice, as if they needed a token of the restoration of justice. As one of them told me recently, "When I went to one of these 'official German doctors' in New York, he questioned me and put me through the third degree as if I had done something to the Germans rather than that the Germans did something to me."

QUESTION:

I would like to know how our panel would respond to the suggestion that these people, whom we have been talking about today, didn't behave properly—that they should have fought back, and the fact that they didn't indicates some defect in their character?

DR. TANAY:

That, I think, is a chapter in itself. I don't think they acted inappropriately. They adapted to a situation in the only way possible given the circumstances. In my opinion, the question of fighting at that particular stage, arises out of a lack of understanding of the situation at the time. When one really studies it, I think the whole issue of fighting as an alternative is irrelevant; what is pertinent is the question of suicide. Should they have committed suicide or should they not have committed suicide? Insofar as I am against suicide in any form, I don't see how they could possibly have fought.

Dr. Sterba has brought up the question as to what success we have for all our efforts as far as the German Courts are concerned. We do not have as much of a problem with the Courts as with our psychiatric colleagues. I don't think they have anything personal against survivors; it is simply a fact that German psychiatry is all too frequently the old organic type of psychiatry. When German psychiatrists receive our reports, they quite honestly must believe that we

are making something up, because the data make no sense in terms of their background. Having been educated at a German university, I know that analytic concepts were completely taboo. In the Psychiatry Clinic at Munich, there was one man who, during the evening, lectured us in something akin to psychoanalytic-type psychology; so, the good doctors find it very difficult to accept our opinions. We find the same situation pertains in this country. Dr. Krystal had this experience with a survivor patient who was sent to a very well known, organically oriented institution here. The report on her indicated that she was perfectly normal, since she fit no single Kräpelinian category; however Dr. Krystal found she was a very sick woman.

We have in effect, an advisory system by means of which we ask the judge to consider our findings. There was a case recently where I had written an opinion. First, Dr. Krystal wrote a report and it was denied; then I saw the patient for the Consulate and the German Obergutachter saw it and also denied it. But upon appeal, the judge said, "I can't understand why the Obergutachter, the expert, denies it inasmuch as Dr. Tanay describes in such a clear fashion that this person is sick; therefore, we sustain the claim." So, again, the judge accepted it much more readily than the psychiatrist.

The German Legislature decided to recognize emotional disability as a cause for compensation claim. This decision is based on the assumption that such damage can occur as a result of psychic traumatization. The law does not exclude psychic damage as such. The German legislators are dependent upon the doctor's judgment as to the presence and extent of such damage. After all, illness belongs traditionally within the domain of the doctor.

It is now a legally accepted fact that the stress of persecution can bring about an illness for which a compensation is due. This is a legal but not necessarily a medical fact, at least for our German colleagues. We thus have the peculiar situation that law is dependent upon the doctor to carry out the administration of a principle to which he may not subscribe.

Now, let us make one more comment on this entire area of compensation, which I think may be giving us an inaccurate picture. I think the "compensation business" is in many ways an excuse for us to get together here, for patients to come to see us, and for many others to become aware of the true situation. Many patients come in

supposedly because of compensation, and they consequently make an entire production of it. This is only in the service of the denial: we are not here as patients; we are not here because we are damaged. I saw a man recently, socially, who said to me (he thought he was joking), "I would never file an application because then I would have to admit that they had done something to me." He thought it was funny, but it wasn't—it was true. Basically he wasn't filing an application because he could not bring himself to recognize that he had been damaged. So I think this focus on compensation is more of a defensive nature.

Three years ago, I saw a woman who was sent for an evaluation, which enabled her to obtain a pension. Two and one half years later she came back and said to me: "I have been told that I can get my pension and still get all my bills for treatment paid. So why don't you give me a bill saying you have treated me for the last two and one half years and we will split the money." Needless to say, she was a person who suffered from very intense symptoms resulting from her concentration-camp experiences. She was highly depressed, experiencing terrifying nightmares and yet, at the same time, she could not allow herself to enter treatment unless it was under the guise of "cheating the Germans." I had encountered this situation a number of times and knew that it could be handled only after a minimal relationship had developed. Hence, my reply to this patient was: "Yes, that sounds like a good proposition." Her response to this was: "The Germans, the miserable Germans, this way we can cheat them after all they did to us." I discussed this with her for three or four sessions and finally ended up with this statement: "We have a choice. Either I become your doctor and treat you, or your business partner. I do think you need a doctor, so I would rather become your doctor than your business partner." She became very angry and accused me of siding with the Germans! Nonetheless, she has been in treatment now for quite some time. She comes regularly although it takes her an hour and a half to get to my office by bus. There have been some remarkable changes in this woman. Originally, she had the typical concentration-camp survivor dreams—the "rerun" dreams, reliving exactly what had happened. Now, she has more complicated dreams which really require interpretation. She has shown marked improvement, but let us recall that it all started on a "let's cheat the Germans together" proposition. Incidentally,

she was able to relinquish this attitude; as was the case in this patient the application for a pension often serves as a substitute for a desperate call for help by these very sick and long-suffering patients.

DR. NIEDERLAND:

The question: "Should they have fought?" now comes up. Of course, as a result of Hannah Arendt's (1963) book, this question is asked with great frequency, be it at cocktail parties or at serious occasions. There is no answer because *there never was anything like this*. There has been no experience, no image, no record, no frame of reference available in recorded history. Even the exterminations by the Huns and by other savages, etc. cannot be compared. This was the Twentieth Century. This was no longer the period of the Huns and the Mongols invading Europe and vice versa; nor was it some goings-on in the African bush; this was in the center of Europe, with the professors and the judges and the law! I think this is a good question because one of the chief murderers looked even more professional than our distinguished colleague. A University Professor of Physiology at the University of Jena became interested in studies of the visual purple in the retinas of living people. In order to find out what happens at the last moment, when the eyes are still living in the eye-ground, he ordered the guards, who were only too ready for this scientific experiment, to remove the eyeballs of 120 living inmates of the concentration camp in order to study their retinas. History has nothing to compare with this degradation of modern man—nothing like that—ever!

DR. BYCHOWSKI:

I would like to add to this, especially the part of the question which has been taken up recently in the English magazine *Encounter*. This magazine published a very dramatic exchange of correspondence between Hannah Arendt and her former friend, the distinguished Professor of Philosophy and Mysticism in Jerusalem, Professor Gershon Sholem. I would like to make only two comments. The first comment is—that nothing like this has ever happened before. Without getting indignant, it is a fact that the process of dehumanization, once it started, went so far that it allowed a certain number of human beings to treat other human beings as

one treats a lobster, out of which you extract the best and then throw away the rest. Lobsters, to us, do not have personalities. This was the attitude of the Nazis.

There have been so many studies, especially in this country, in what is called the "psychology of leadership," so important for the war, for social movements, for industrial psychology, for organization of groups, etc. We know that those people who had a very strong collective superego and who were imbued with fighting spirit—those people fought. Take for instance the famous resistance of the Warsaw Ghetto. Who were those people? They were Jewish Socialists, the famous Bund, people who were trained to fight. They had fought the Polish anti-Semites, the Nazis, the reactionaries, and they fought well. They did not allow themselves to be taken alive. To say that this should have been the policy of a whole people, surrounded by enemies, seems to be absurd and, as Dr. Niederland said, it indicates a complete lack of empathy and understanding. It is very easy to discuss it in an armchair, from a purely intellectual point of view. This collective superego may make the fight possible. The victims we see today, whom we are trying to describe to you, people who still display the syndrome of complete hopelessness, are not former specialists or former idealists—they are what the Romans called "*Simplex Servus Dei*," a simple servitor of God, simple people. Not everybody has great ideas. It is wonderful if we have them, but human beings have not been created for ideas; all they want is to be alive. To deduce from this that the Jews had unconscious suicidal strivings, etc., seems to me absurd.

Yet, there are other situations. We have a number of very gifted, very talented, very special individuals like Victor Frankl, who survived a concentration camp; or the very distinguished Bruno Bettelheim from Chicago. Why? Bettelheim found that in being able to maintain a great moral strength, an inner attitude in the camp, he was able to avoid ever surrendering to the guards and was consequently able to survive. Let me again mention the former student of mine who was deported to the Arctic and who, on a recent visit described to me how he was questioned by the Russian secret police in the Arctic Circle, how they wanted to crush him, brainwash him to the point where he would admit that he was a spy, etc., and how he acted. He was able to come out of it all relatively unharmed. Such men are very special individuals, who are endowed

with tremendous moral scaffolding. Can we demand this from everybody? Have people been created by God to have special courage? It would be wonderful if they had it, but to blame them because they didn't have it, or if their religious training taught them not to fight but to pray, that is preposterous and absurd.

V. Forensic Psychiatry of Schizophrenia in Survivors

INTRODUCTION: THE MASSIVELY TRAUMATIZED INDIVIDUALS AS A CHALLENGE TO HUMANE MEDICINE

DR. DORSEY:

It is my privileged responsibility to open this conference devoted to that human experience which so overwhelmed the mind's capacity for self-responsibility. Just to get the door ajar a bit, I offer a statement of an American Medical Association medical consultant for the Secretary of War in 1946 (Ivy, 1949). This man, an expert witness on scientific and ethical subjects at the Nuremberg trial of the Nazi physicians, found their cruelties incredible:

I must confess it was difficult for me to believe that physicians could have committed the atrocities with which these Nazi physicians had been charged until I had read the official documents. It was inconceivable that a group of men trained in medicine and in official positions of power in German government circles could ignore the ethical principles of medicine and the unwritten law that a doctor should be nearer humanity than other men and that all experimental subjects should be volunteers [p. 132].

Alertly he adds that the philosophy of the Nazis is based on the immoral principle enunciated by Bethmann-Hollweg in 1914, "Necessity knows no law."

Enough for a beginning. What I am about to add may also seem "traumatic." However, as the University Professor I deem it my duty to say to myself, here and now, not merely what my fellow man may wish to hear, but surely what I consider he ought to hear. Each one present may observe for himself the extent to which self-insight

seems to vary for each of his colleagues, as well as for himself, from one personal experience to the next. The solipsistic position of the Jewish-Christian ideology, *I am that I am*, is the most difficult position to live with without some conscious or unconscious rejection (repression). To wit, note the evident aversion to considering "The kingdom of God (*all*) is within one," or "Love thy neighbor as thyself," or "Love thy enemy," or "Everything is in its causes just," and on and on. A man cultivates meritorious efficiency for his task assignment by his working up his readiness to consider its right to be as identical with his own. Ideal justice is enabled only by the judge's consciousness that he is his only judged one.

First of all then, I consider my mind to be traumatized in any area of its living which I must categorize as "not-I" living. Furthermore, I extend the meaning of trauma to include any and all of my mind's make-up which I cannot identify as being necessary, hence real, hence best evaluated as worthy of my finest and kindest and most insightful appreciation. The very term "trauma" is widely suspect as a pejorative one, furthering the illusion that repression must best be treated by further repression. Such respectable seeming words as "accident," "illness," "attack," "injury," "disorder," are firmly rooted in a materialistically oriented type of self-education. Indeed every so-called objective term supports the illusion of materialism which the consciously spirited, subjectively imaginative, modern medical man wisely and thoroughly renounces. Quite as Henry Margenau, Yale's Eugene Higgin's Professor of Physics and Natural Philosophy, observed and recorded: "Materialism was a respectable philosophic view at the end of the nineteenth century; it has now become an anachronism."

In order to work on the subject of massive trauma, I must develop in myself the conscious tolerance to be able to feel equal to it, feel my self-sameness in it. Each of us in his work finds the wisdom of living only in his appreciation of his own life. Often, to my dismay, I have had to discover only self-depreciation in all of my detraction of my frantic fellow man. Such self-concealment offers itself most temptingly in my living of my fellow man's extreme self-unconsciousness which enables him recklessly to disregard, ignore, neglect, and destroy himself, by deluding himself that he is murdering his (self-repudiated) enemy. The experience of expansion of my consciousness to cover my "Nazi living" involves the most difficult

stretching of my sense of personal identity. *But the safety of my life lies in its being conscious.* A vital difference between my conscious living and my unconscious living is in my freeing myself from unconscious expressions of my hatred (injured love) through renouncing bitterness, revenge, and more-human-than-thou attitudes which favor my giving life to signs and symptoms of my self-irresponsibility (e.g., headaches, ulcers, high blood pressure, or susceptibility to such life-impairing developments as tumors, accidents, and the like). I best serve "the common good" by taking the best possible care of myself, which includes my interest in seeing my fellow man's living his life caringly.

Thus, I have had to extend the range of my self-consciousness to include whatever I hate or fear or repudiate most, in order to be able to work insightfully as a psychiatrist. Otherwise, I must use my difficult work methodically in the service of (self) repression. How could I identify myself with concentration-camp living?

I first came to my true understanding of that most difficult concept, "a concentration camp," primarily by becoming insightful about the way I lived each of my own family members, in living my own home. By the time I had grown myself for two or three years I was pretty thoroughly brain-washed, pretty thoroughly "traumatized." As I began to learn my so-called common language, I did not realize I was creating a built-in self-deception system providing my appearing to be able to go out of my mind, to live much of my life as if it were not all mine. I am thoroughly familiar with the picture of home as standing for Harmony of Mind Everywhere; and I like the word-picture, "the sacred portals of family living." All of that is good. I happened to enjoy giving birth to a loving mother, giving birth to a loving father, each of whom had an unusual amount of self-tolerance—at least I came to recognize that later on in my life. Therefore, it was not easy for me to create the insight that all of my mental therapy consists of my developing peace with everyone of my family, and with anyone else who stood for a member of my family. Yet, from my continuing self-analysis, I discovered only that.

It seems to me that in this third conference of its kind, it might still be peaceful and gentle to ask myself to consider searching out the goodness in trauma, the goodness in horrible, terrifying, inconceivably overwhelming conditions. After all, it is all my life that I

must live, just as each one of you must live only your own life. It seems very easy to live on and through that life attacking myself in the name of the Nazi terrorist, the Nazi hatemonger, or whatever name I may give to this experience of my very own self.

As is every psychiatrist, I am often called on to live ("examine") a murderer. The farther away I remain from him the more indignant I can be, the more moral warmth I can summon, the more I can say, "He shouldn't have done it." However, the more I study the facts with regard to his behavior, the more I must acknowledge that *he should have done it*, as well as, *how fortunate it was he had not done it before, or more often*.

A great and not always overlooked good in my Hitler was his showing up, really in such a lurid way, the actual conditions existing in his Germany. This is a difficult perspective to have, but it would be life-enheartening if, along with every other way of living this conference, there may creep into it, now and then, this realization: *Whatever did happen happened properly on account of the fact that everyone was there and in the condition which made it necessary for it to happen*. Oh what a painful view that was to me when I first created it! How much I may prefer to say, "He shouldn't have done what he did," than to say, "Actually, the facts of that person's life support the necessity for his behaving as he did, just as the facts of a tiger's life make understandable the animal's ferocity."

A conference is for the purpose of the study of the facts. Long ago, scientists discovered that one cannot be a fact finder and a fault finder at the same time. I can see conditions which are horrible, which fit the crying out of the psalmists, "Even if I make my bed in hell, God is there." It is possible to see conditions which I cannot yet live with the feeling of justice. It is good that I can thus "traumatize" myself, so that I can get away from facts which have such an overwhelming connotation, in order to carry on with what conscious selfness I can summon. It is good that I may at another time, possibly at a conference such as this one, return to the same set of facts in a further effort to see and feel that I am living the awful fact rather than that the dread fact is living me. I have discovered, as a therapist of myself, that there is not any idea, or any view, or any feeling of a human being which is not wisely lived kindly, by realizing its nature, by realizing that it is a part of my human being. That was a difficult life-lesson for me to take on—that it is to my benefit to learn to use

my mind, my life-giving imagination, in order to live everything human as mine, so that *it* will not appear to be controlling me.

May I safely shun the kind of unconscious living relied upon by my Nazi. Certain ideas were living him. Thus he supported a "tail wagging the dog" system of psychology. I recently watched the TV presentation of the Nuremberg Trials and saw the extent to which my beloved fellow men seemed unable to live with kindness the awful conditions which were not inhuman but were committed by human beings. Is it safe or sane to dispose of this potential self-consciousness and its compensatory painfulness merely by saying, "It is not human"?

I do not know what will emerge from this conference, but it would be truly wonderful if some kind of a declaration, similar perhaps to the Declaration of Geneva, might appear. In no other way can the most valuable lessons of life be learned, except through observing the enduring of what must happen when they are not learned.

The work I am asking myself to do in a conference of this kind is the hardest work imaginable. My success in it can be measured only in terms of my being able to consider the awful so-called inhumanity with which it deals as being my own living, living which before I could only live pharisaically. The temptation to claim I am more-virtuous-than-thou, more-the-peace-maker-than-thou, is ever very near to me. I am thus grateful for this opportunity to speak my hard-working mind on its most difficult topic: the wisdom in conscious self-responsibility.

DR. KRYSTAL:

I think that it is very important that we stop and consider this point of view. We have a very difficult subject to cover today: the problem of schizophrenia in relation to the aftereffects of persecution. No matter what we do and no matter what we say, we will be up against forces which will necessitate that we make a choice of how we want to deal with them in our individual minds. I think that it is incumbent upon us to own up to the pain which will be consciously experienced through the reliving of our data.

All of us who work in this area know that it is a potentially traumatic experience merely to interview a survivor of persecution. We also know that, unfortunately, we do not always do well with it. Sometimes we have to fend off any information or any contact with

these people. We must make a choice as to the uses of ourselves. Arthur Miller describes this act in "After the Fall": "The choice that one *has* to make, and to choose one must know one's self, but no man knows himself who cannot face the murder in him, the sly and everlasting complicity with the forces of destruction." It is essential that we keep our mind's eye on these forces within us in order that we may deal with our "victims," our "perpetrators," with kindness, for this is the way that will not be harmful to ourselves.

We shall now consider the problem of schizophrenia. To start with, there were great differences in the conceptions and ideas between psychiatrists in Germany and those outside of Germany because of the historical development involved. It has become apparent that the last five years have seen considerable agreement on certain problems, such as the problems of survivor guilt as a factor in causing chronic depressions. But for the most part, one problem has remained impossible to solve—that is the problem of schizophrenia and its relationship to trauma. Our very capable guest is up to this challenge; he is Professor Dr. Ulrich Venzlaff, Director of the Psychiatry Clinic at the University of Göttingen. It is interesting that he himself studied with Professors Ewald and Conrad, who were among the most conservative organicists that ever appeared on the psychiatric scene, and yet, because of his personal courage and intellectual honesty, he was able to free himself from the rigid doctrinaire pronouncements and to allow the clinical evidence to speak for itself.

Last night, Dr. Niederland asked him a very simple question, "How did you do it?" Dr. Venzlaff gave a very simple answer; he said, "I started listening to my patients. I listened to the first patient five hours when I realized that the books just weren't right."

After this, nothing else need be said about this man, so I give you Professor Dr. Ulrich Venzlaff.

PROFESSOR DR. ULRICH VENZLAFF:

If a Gallup Institute would take a poll of the psychiatrists of the world today, asking about their greatest professional wish, I believe the majority of our colleagues would voice the hope that the riddle of schizophrenia be solved in their time. Although schizophrenia is the most prevalent psychosis in all countries of the world, agreement is lacking regarding the problems of diagnostic etiology and

treatment. The last surveys in the German language, taken by Bleuler (1964), Benedetti et al. (1957), and Benedetti et al. (1962), indicate that more than 5,000 articles were written on the subject expressing widely divergent opinions.

The immensity of problems which we encounter in schizophrenia precludes a fundamental and exhaustive representation in the context of this lecture. Neither can we evaluate the relative merits of varying opinions of divergent diagnostic limitation and etiology. In accord with this workshop, I shall limit myself to problems of forensic psychiatry. I shall propose a view which reconciles the present status of our factual knowledge with the functions assigned to us by the German Restitution Law.

In regard to schizophrenia, schools of psychiatry have developed and pursued many different trends, which diverge so markedly as to give the impression that the authors are speaking of completely different disease entities. But whatever trend we follow, with whatever school we associate ourselves, and under whatever aspect we consider schizophrenia, sooner or later we reach the limitations of our knowledge, which have not been surpassed by any investigator.

The classic view of schizophrenia, of course, is that of the geneticist. We cannot neglect the fundamental investigations undertaken by Rüdin, Elsaesser, Kallmann, and Slater, et al. concerning homozygotic twins, which show us a correlation in the incidence of schizophrenia in both twins in at least 70 per cent of the cases studied. Other observations are less clearcut or convincing. If, for example, children of two schizophrenic parents develop this reaction 40 times more than the average population, and children of one schizophrenic parent 20 times more, then we have not proven that heredity and not the effect of the interpersonal relation was the etiological factor. European psychiatrists believe that one cannot doubt a hereditary factor, but have not been able to set up principles of heredity concerning predisposition to schizophrenia. Even the correlation in homozygotic twins is subject to environmental or interpersonal interpretation when we consider the later studies of Kallmann, which showed a fall in the correlation in twins who were separated early from each other and grew up in different milieus.

The neurophysiological research into the somatic cause of schizophrenia, in spite of decades of most intensive research, has failed to prove any somatic etiology. However, we cannot completely rule out

somatic causes of schizophrenia from consideration. My teacher, Conrad (1960), who unfortunately died too early, had emphasized, along with such men as Weitbrecht (1959), the fact that every symptom of schizophrenia can also occur in the course of acute or chronic brain syndrome. He pointed out that today there can be no sharp distinction, on the basis of symptoms alone, between the brain syndrome and the endogenous psychoses. The psychiatric literature contains an abundance of observations of cases of psychoses in which organic brain damage was proven, and yet a schizophrenic course and symptoms prevailed. Conrad has questioned whether the somatic damage does not perhaps produce the same X factor which also contributes to the genesis of "genuine" schizophrenic psychosis. In 1958, at the Psychiatric Clinic in Heidelberg, Huber performed pneumoencephalographic investigations of a great number of chronic schizophrenics and found cerebral atrophic changes, especially at the third ventricle, in a number of cases. These results suggest that in the course of time an organic defect could develop in chronic schizophrenia. Such an occurrence would allow for the reconsideration of the work of Janzarik, who found a most striking similarity between the psychopathological pictures of chronic brain syndromes and chronic schizophrenias. The biochemical problems of schizophrenia remain unsolved despite great scientific interest and research. I will mention a few: the work of the Canadians, Hoffer, Smithies, and Osmond (1958) and their observations in experimentally produced psychoses, similar to schizophrenia, through the action of adrenochrome, suggests the possibility of autogenous toxins. The interesting problems of metabolism of serotonin and of catecholamines, and above all the striking effectiveness of drug therapy in the psychoses in the last 15 years, have all stimulated organic research. The results of pharmacotherapy cannot be explained solely on the basis of a toxic-sedative effect, but impose the scrutiny of a specific correction of morbidly disturbed brain metabolism. Our failure to prove a biochemical substratum of schizophrenia is no persuasive counter-argument; even when we produce psychosis experimentally with mescaline or LSD (Leuner, 1962), we cannot demonstrate the presence of these hallucinogens in the organism by any biological or chemical methods. Psychosis can be produced by a dose so small that it defies the imagination—the dosage of 30 millionths of a gram. Neither can we ignore the improvement obtained with the introduction of

somatic methods of treatment, at first insulin and ECT, and later pharmacotherapy. Despite the interesting considerations gained from these therapeutic experiences, there is still no tangible proof as to the existence of physiological causes of schizophrenia, nor have the neurophysiological, biochemical or chemical effect of somatotherapeutic procedures been clearly worked out.

The third aspect of schizophrenia is the dynamic one. The dynamics of schizophrenia are most complex, and require an entirely different frame of reference. We are now concerned with the environmental factors, the interrelation between endogenous and exogenous factors, the purely psychological causes of schizophrenia. At present, all schools of psychiatry agree that the influence of environmental factors is important in the development of the symptoms of psychosis. Some symptoms considered only 20 years ago to be pathognomonic of psychoses have been proven to be psychogenic artifacts of the asylum subculture. The results of favorable effect of occupation, milieu, and social therapy have expanded our therapeutic repertoire. The clearing up of massive chronic schizophrenic symptoms under severe somatic illness or stress has been reported repeatedly in many decades. K. Schneider (1935a) reported from his experiences in World War II that the most withdrawn psychotics respond appropriately to acute situations of danger (bomb attacks, enemy occupation), and exercise proper judgments.

The view of "classical" psychiatry, denying meaning to delusion or hallucinations, is no longer tenable. Continental psychiatry, Existential Analysis (*Daseinsanalyse*) (E. Strauss, Binswanger, von Gebattel), as well as the medical anthropology of Zutt, Kuhlenskampff, and others, have especially sharpened our search for the meaning of the contents of psychotic productions in terms of the patient's life story. In acute schizophrenia, and especially in the "mixed" type of schizophrenia and borderline patients, we find meaningful connections between the patient's life story and emotional conflicts, as well as "reality" problems and the nature of their symptoms. The influence of these observations on European psychiatry has been to lessen its preoccupation with the organicist view exclusively. Prior to this, such men as Binswanger (1957) and Zutt (1953) were instrumental in minimizing this hyperconcern with pathogenesis and stressed the need to analyze the situation and the psychic reality: the "world" of the patient, his unique "structure of

his being-in-the-world." This view helps us to understand more intimately the patient and his world, although the question of pathogenesis may remain without a definite solution.

In organic brain disease caused by alcohol, arteriosclerosis, cerebral atrophy, etc., we can still demonstrate the dynamic genesis of the patient's symptomatology. We do not attribute the chronic brain damage to the patient's emotional problems. But we do recognize that multiple forces, organic and dynamic, may fit into the framework of a multifactorial manner of consideration (Villinger), and that these may vary in importance from case to case. In this respect, psychoanalysis, since Freud, has developed in its own somewhat different way. From the depth-psychological aspect, particular regard was bestowed especially on the emotional factors of early infancy, the interactions within the parental home, and of the relations with the mother. By this emphasis, the analyst became concerned with the "broken-home situation," the "overprotective mother," and, for example, the investigations done by Lidz concerning deep disturbances of the family structure in many cases of schizophrenia. The German neopsychanalyst, H. Schultz-Henke (1952), believes to have found the contributory factors of schizophrenia in isolation from and rejection by the parents during the time of extreme helplessness in the first year. Schultz-Henke further feels that these individuals fail to develop a feeling of confidence and security; they feel estranged, and experience the world as dangerous, and have a tendency to isolation and withdrawal. The contribution of psychoanalysis has been to highlight the mental material, which was not sufficiently valued by classical psychiatry. The high incidence of disturbances and abnormal traits in the families of schizophrenics cannot be neglected. However, this overview opens the question as to whether the same predispositional factors are not responsible for both the abnormal individual traits and the resulting disturbances of the family structure. In regard to the etiology, schizophrenic predispositional factors, as well as environmental factors, mutually conditioned by each other appear to work together. I consider this to be the present view of psychoanalysts and "depth psychologists" (I refer here especially to the American writers: Hill, Eissler, Erikson, Lidz, Fromm-Reichmann, Searles and Will) who maintain that the patient escapes from an untenable world and his insoluble conflicts by altering his internal representation of reality.

According to this view, schizophrenic symptoms represent an unsuccessful attempt to integrate with unbearable reality, an intolerable psychic state. Erikson (1959) places special emphasis on puberty, when pathological crisis cannot always be distinguished from schizophrenia. In German psychiatry, Kretschmer (1956) has also stressed the crucial role of puberty, although he concentrated on the somatic aspects. The transition of puberty crises into hebephrenia has been too frequent to escape notice. The "escape from reality" in schizophrenia cannot be denied even by classical psychiatry. It is my opinion that a truly comprehensive study of schizophrenia must be completely eclectic. At this time, we cannot rule out or ignore any view. The contribution of dynamic psychiatry has been of greatest value in providing the basis for the many forms of psychotherapy which have grown out of this movement. (Among the European psychiatrists, I mention here: Storch, Benedetti, Matussek, Winkler, Schultz-Henke.)

After this brief survey, allow me to consider the practical questions which are of interest to us here. Psychiatry today is not in a position to give the definitive answer to the question of the causes of schizophrenia, an answer which would be accepted as binding by all psychiatrists the world over. M. Bleuler (1964), one of the most respected psychiatrists of the continent, recently concluded a most illuminating paper in which he discussed the standpoints and aspects of the teachings on schizophrenia: "I am conscious that all these considerations and theories may become meaningless tomorrow through the pioneering discovery of a future Nobel Prize winner."

We cannot solve the problem of schizophrenia at this time, but I believe that, with all differences of theory, we can come to an agreement on the legal problems. I feel that in practical medicine we have greater accord, and this applies both to therapy and forensic psychiatry.

The German Restitution Law provides a framework for communication insofar as it raises the crucial question of the relationship between schizophrenia and the suffering endured by the victims of concentration-camp imprisonment. The textual formulations of the law and of the judgments of the German high courts obligate us to limit ourselves in considering these questions, not only to the presentation and scientifically plausible causal relations (as we have before us, say, in traumatic damages) but to a very specific answer. Even

though we cannot, at the present time, rule out any theory of causation, nor embrace any single cause, we have to consider each factor for its ability to exacerbate such predisposed conditions as may exist. Only in schizophrenia which existed before the persecutions, or in cases of clearcut "constitutionally-conditioned" problems, can we rule out the influence of persecution as a contributory cause. Wherever we prove the effect of the persecution to be of psychogenetic significance, we are obliged to acknowledge it. According to the German administration of justice in those cases, whenever the after-effects of persecution causes 25 per cent disability or is one fourth of the factors, the suffering must be pensioned and acknowledged "in the sense of essential contributory factors" in the full extent as suffering from persecution. Even if we cannot in any branch of medicine, and least of all in such a puzzling illness as schizophrenia, measure precisely the relative importance of the several pathogenetic factors and determine them in terms of percentage, this interpretation of the law states that illnesses in which the preponderance of the causes can be attributed to constitutional factors or influences independent of persecution can also be acknowledged as the after-effects of persecution if the stress factors of persecution are responsible for the precipitation of the current illness. The expert is obliged to demonstrate that the influence of persecution is at least "probable" as a contributory factor. He does not have to prove his thesis, but must show that there is a greater likelihood of a contributory cause, since the law requires only the establishment of a "probable" cause.

Earlier experiences have shown us that the effect of exhaustion alone has no influence on the endogenous psychoses, since after World War I in cases of catastrophes or severe traumatization, we did not find any increase in schizophrenia or manic-depressive psychosis.¹ A comparison of the incidence of mental illness between the neutral and warring nations fails to prove a direct relationship between mental illness and war stresses. Schizophrenia is not a typical effect of extreme conditions, as for example malnutrition and epidemics. The late sequelae of severe stresses generally take the form of chronic-reactive depressions and characterologic changes in younger people. Insofar as there have been no adequately controlled

¹ Bonhoeffer (1922) in Germany surveyed the experiences of World War I and concluded that "tolerance of the psyche to the effects of exhaustion may be regarded as almost limitless."

studies on the frequency of schizophrenia in concentration-camp survivors, we cannot draw any statistically significant conclusions. Thus we are unable to generalize as to universal validity. Some experts who deny the relation between persecution and schizophrenia cite the work of Kral (1951). Kral states that in the Theresienstadt concentration camp there was no increase in psychotic illnesses. However, conditions in Theresienstadt were considerably better than, for example, in Auschwitz, Bergen-Belsen, and Maidanek. It has been generally assumed that the prisoners who became psychotic were promptly exterminated, although we have no actual reports concerning this supposition. In my own experience, I have examined three concentration-camp survivors about whom there was uncontested evidence from witnesses who had been fellow-sufferers at Auschwitz, that the former had shown schizophrenic symptoms in the camp but nevertheless survived. The reason for this may be, as already mentioned, that up to a certain limit, in extreme situations, even schizophrenics will respond with an astonishing degree of adaptive behavior. There is also evidence that under extreme somatic stress (malnutrition, exhaustion, terror), the more conspicuous symptoms of schizophrenia do clear up and are masked by reaction to the concentration-camp situation. W. Schulte (1953) has even presented the interesting view, from his postwar experiences, that acute stress can prevent the outbreak of a psychosis, which may develop after the emergency is lifted. He observed that after life returned to normal, many people developed a variety of symptoms. His experiences were with returnees from prisoner-of-war camps, refugees from East Germany, and displaced persons who, upon returning to normal life, became psychotic or started to complain of neurological disorders which had been long in developing. Kornhuber (1961), in his survey of prisoner-of-war pathology in the German handbook of psychiatry, *Psychiatrie der Gegenwart*, pointed out that the time of liberation can be the precipitant of psychosis. Do we have adequately controlled statistical studies on the incidence of endogenous psychoses in concentration-camp survivors? In 1959 Eitinger published his investigations, from which we learn that among persecuted immigrants in Norway, the incidence of psychosis was five times higher than in the native population. In *Concentration Camp Survivors in Norway and Israel*, the same author (1964), describes a group of 100 hospitalized psychotic patients, 62 per cent

of whom were found to be schizophrenic. After having excluded 21 patients showing hereditary taintings, deviating traits during childhood or later, and patients with tuberculosis in childhood, 41 remained. The disorder broke out in 30 cases in direct connection with the camp internment; in four others there was, at the same time, a noticeable change in personality. W. von Baeyer (1964) reported on 37 persecuted patients, in 21 of whom a connection between persecution and the outbreak of illness was recognized. This corresponds to the rate of psychosis reported by Eitinger. My own impression, from working with soldiers and prisoners-of-war is that often a connection between illness and severe persecution experiences seems clear. Although we are dealing with small patient populations which provide no statistical significance, these impressions are of scientific interest because they contradict earlier opinions and thereby provide us with an incentive to examine each case with special care. As a matter of fact, even the older psychiatric literature does contain a number of reports concerning a coincidence of schizophreniclike symptoms and severe somatic injuries. Panse (1949) has reported on a number of cases, in which the onset of schizophrenia coincided with severe infection. Elsaesser (1953) has published interesting reports about the appearance of schizophrenia after severe cerebral injury. Kurt Schneider (1935b), who was very conservative in this regard, had to admit the possibility of contributory factors in a few observations from World War I, concerning the outbreak of schizophrenia following shock or wound. Some years ago, Kolle (1958) reported a case in which schizophrenia occurred in connection with severe famine disease.

Another question posed by these observations concerns the development of schizophreniclike symptoms in organic brain damage. K. Schneider (1950) reported one case of carbon monoxide poisoning which had a lifelong history of "classical" schizophrenic symptoms, and the autopsy disclosed the typical anoxic brain damage. Perhaps a "multifactorial" or "multiconditional" interpretation of schizophrenia is necessary. It is likely that the somatic injuries evoke the schizophrenic process in individuals predisposed to it. We might postulate with Mayer-Gross that the precipitant would be the disturbance of the autonomic nervous system. In hebephrenic schizophrenias, where somatic process is suspected, at least in the "hard-core" cases, and where dynamics are poorly manifest, the organic

process is more weighty. In my own three cases, in which the schizophrenic manifestation could be shown even during the internment at the Auschwitz camp, I feel that the extreme somatic stress was later responsible for a very severe and destructive form of schizophrenia. Because of these considerations, I am inclined to disagree with von Baeyer and to postulate the possibility of "essential contributory causes" of schizophrenia by the type of severe somatic stress imposed by persecutions. K. Schneider's opinions, widely accepted in German psychiatry, postulate that a contributory cause can be acknowledged when:

1. There is no evidence of hereditary taint.
2. There is no history of abnormal or prepsychotic traits.
3. There is a strong suggestion of a temporal connection between the onset of bodily damage and the onset of schizophrenia.

I have presented this view in an earlier paper entitled "Schizophrenia and Persecution," and Kolle seems to have come around to this point of view as well.

K. Schneider (1950) has carefully specified the exceptional conditions under which a very severe emotional disturbance could be recognized as a partial cause. (Kolle pointed out that severe emotional problems could be more disabling than physical illness.) In two cases, in which I had to render an opinion, there was such a convincing connection between the manifestation of psychosis and a severe emotional stress of persecution that contributory causes were obvious beyond a shadow of doubt.

The first case dealt with a female patient who was born in 1925 in Leipzig and raised there, and who emigrated in 1939 with her parents to Paris. From Paris, she fled further into unoccupied France, after the invasion of the Germans in 1940, and had to exist under very difficult conditions. In August of 1942, she was imprisoned in a night raid by the Vichy police and was transported away in a truck with other prisoners. On the truck journey, she developed a severe condition of excitement which increased at the point of assembly, so that she was transferred to a mental hospital. After six months of treatment with Cardiazol and electroconvulsive therapy, she was released. The case records of that admission show typical schizophrenic symptoms. Upon imprisonment of the father, the mother and daughter fled to a convent. After the war, the patient went to school, did her entrance exam for the university, and married in 1947. In 1953, her condition developed into a full-blown

schizophrenic reaction with delusions of persecution and having a mission to bring peace to the world. Later, after a remission, she attempted suicide and had to be treated for some months in a mental hospital again. In 1960, E. Minkowski made the diagnosis of a typical schizophrenic defect. Medical reports from 1947 and 1953 show that there was already a chronic depression ("il persiste de la tristesse"), fleeting delusions, and chronic anxiety. There was, therefore, a "bridge" between the symptoms of 1942-3 and 1953. Her health before the persecution had been good; there was no evidence of any abnormal character traits or of hereditary taint.

Whereas this is an example of a strictly temporal connection between acute anxiety stress and the manifestation of schizophrenia, the second case shows anxiety of a long duration:

This patient, born in 1913 in Czechoslovakia, was the daughter of a doctor. In 1932, she married a Hungarian businessman and moved to Budapest. In 1933, their only son was born. In 1942, she received the news that her brother in Prague had been deported, and somewhat later, the report of his death. Her parents saved themselves by fleeing to Budapest but were imprisoned there. After great difficulties, she succeeded in freeing her parents and managed to hide them in Budapest. Subsequently, she had to care for them, provide food without ration cards, and obtain "false papers" both for them and herself. In 1943, her husband was imprisoned and taken to a labor camp, where he fell ill with spotted fever. He was taken to a military hospital but managed to escape despite severe illness, and was able to get to Budapest where his wife hid him in a different part of the city. She was now taking care of three persons. After the collapse of the Horthy government and the German occupation of Budapest in 1944, her second brother was deported and she had to wear the yellow star badge on her clothes. When the ghetto was established, she hid her 12-year-old son with friends, while she herself took refuge with a family of workers. During the bombardments by the Allied Air Forces, her visits to her parents and husband became more hazardous. During the Eichmann drive to send all Hungarian Jews to Auschwitz, she had to give up her hideout and flee from one place to another. During the entire time, she managed to withstand the dangers to herself, and provided food for everyone in her family. A doctor, who knew the patient for many years before the persecution, and who was hidden near her, later reported that during the time of greatest pressure the first symptoms of schizophrenia appeared. At that time, she felt persecuted by her own friends and developed

the delusion that she had the stigmata of crucifixion on her hands and feet (she received her education in a convent school and changed early to the Catholic religion). She continued helping her parents, husband, and child with great caution and self-control, and thereby developed a most unusual degree of resourcefulness as well as a sense of destiny which is seldom found. After liberation, she had a partial remission of her delusions for two years, but after emigration to the U.S.A. she developed a full-blown schizophrenia within a year of her arrival in America. The psychiatrist who examined her in relationship to health damages from persecution made the diagnosis of chronic paranoid schizophrenia.

The above case demonstrates the temporal connection between a long-lasting state of anxiety and manifestation of schizophrenia, as well as the patient's "escape into psychosis" from an unbearable reality. Even the most conservative psychiatrist would recognize that anxiety and persecutions were at least *one* of the causes of the illness. To couch these observations in the somatic terms of Mayer-Gross and K. Schneider, one could say that the emotional stress in cases of acute or chronic anxiety leads to a significant vegetative-hormonal disturbance and evokes schizophrenia through somatic links.

Another way of interpreting the background of the second patient would be to emphasize the pathogenic influences of the chronic anxiety, destruction of the family, security, and total uprooting. In 1929, Erwin Strauss in an ingenious investigation, "Event and Experience," pointed out the pathogenic effect of an event on the psychic reality of the patient and the unique way the event is experienced. Although we have no reason to believe that either actual danger or physical exhaustion would cause schizophrenia, we have to take a different position in relationship to events which destroy the whole existential meaning of a person's life and rob him of all of his love objects, defenses, and ideals. A significant proportion of psychoses which were earlier considered exclusively "endogenously caused" can be shown to be a reaction to an existential crisis. The common examples of such reactions are: the psychotic development in a disturbed adolescent, the paranoid reaction to loss in middle age, and the involutional melancholia in reaction to the uprooting and isolation in old age. In all of those instances, we can approach the patient from the genetic no less than the dynamic point of view. When we start looking for the individual's life story, we can demon-

strate, even in cases with hereditary taint or organic predisposition, the unbearable disruption of all meaningful object relations, isolation, uprooting, and loss of security.

The following illustration shows the influence of such factors in a case in which there was no gross threat to life, incarceration, or somatic stress:

Dr. Z., born in 1896, was a wealthy and prominent physician, practicing in Breslau. His hospital was confiscated after the Nazis came to power. As a Jew, he was forbidden to continue to treat the health insurance patients. Gradually, he was deprived of his civil rights, until finally practicing medicine was completely forbidden to him. He succeeded in sending two children to England, and he, his wife, and third child emigrated a few days before the outbreak of war to Chile. His mother and sister had to remain in Germany because of a lack of money. In Chile, he was forced to settle in an inhospitable area in the South. Not having a Chilean license to practice medicine, and finding no other work, he was continually in trouble with the authorities. Having been warned to "cease and desist," he began to develop delusions of persecution, at times so gross that he hid for days in the mountains or forests. He became progressively more depressed and withdrawn. He worried about not hearing from his mother and his children in England, who he felt were deprived of a proper education. The condition became increasingly worse and moving to a large city brought no recovery. In 1942, Dr. Z. became aggressive, violently disturbed, broke the furniture, and attacked his family. He believed himself to be persecuted again by the Gestapo, fearing that someone wanted to poison him and had spied upon him. He left his family and moved into a wooden hut at the edge of the city, completely neglecting himself. He threw stones at every visitor, even his wife, who was only permitted to leave his daily meal at a distance of 10 yards from the entrance. He did not touch the food for days and only ate it when it was completely spoiled. A psychiatrist, who forced himself into his hut, diagnosed chronic paranoid schizophrenia.

I wish to re-emphasize that Dr. Z. suffered his first nervous breakdown with severe depression when he was forbidden to practice medicine while still in Germany. We see, in this case, the close temporal, thematic and, in my opinion, causal correlation between the psychotic illness and the many psychic traumata. These consisted of the degrading expulsion of a man from his social order of rank,

his isolation from other human beings, and the collapse of the family structure. Following emigration, the uprooting and "illegality" of his work were the final unbearable blows. Ødegaard (1932), Pflanz (1962), Murphy (1955), and many others have reported a higher rate of psychotic illnesses in immigrants. Murphy has referred especially to the sharp rise in admission of psychiatric cases, with persons who were formerly persecuted, after emigration and release from the protective atmosphere of the D.P. camp. H. Krystal (1963) wrote an interesting depth-psychological study of this problem.

In this connection, the previously mentioned investigations of Eitinger (1964) on psychotic illnesses in Israel might be cited again. All the patients investigated by him, in whom schizophrenia broke out soon after imprisonment, "had suffered from severe isolation problems immediately after their arrest." None of them had been placed in a camp with parents, siblings, relatives, or friends. "There was thus no one who could help the patient to link the present experiences with the past." Von Baeyer felt that the collapse of familiar and social structures in connection with emigration was especially significant in his acknowledged schizophrenic patients.

In terms of forensic psychiatry, I would like to add to the criteria previously set down by K. Schneider, as well as to my own previous work, the emphasis on recognizing the contribution as an "essential cause," the influence of "powerful dynamic associations." The destruction of an individual's existential systems, values, and relationships, has an irreparably damaging effect.

When we look for support of our assumptions of causality to the time-sequence of events, we must not indulge the naïve expectation that the onset of schizophrenia, if it is caused by incarceration, must develop immediately upon the release from the camp. On the contrary, in most schizophrenic syndromes, one can expect a symptom-free period. The natural history of schizophrenia includes a period of "incubation," a silent development in which the symptoms are not at all conspicuous. The circumstances of liberation from concentration camps were especially conducive to the delay of symptoms because of months of hospital care for physical exhaustion, and because of the protective atmosphere of the D.P. camps. Where the period of "incubation" lasted for several years, we can expect some "bridge symptoms" in terms of personality change, difficulties in adjustment, and in interpersonal relations. Von Baeyer pointed out

that we should take particular note of "bridge symptoms" appearing in life situations which derive secondarily from the persecutions; for instance, in uprooting, we might examine carefully the patient's attempts at re-establishing a social situation.

In regard to the manic-depressive psychoses, the hereditary tainting is much higher (75 per cent according to Kielholtz), and there are different considerations. Our generally accepted perception of the circular psychoses is that they are, as Weitbreck says, "unaffected by the environment" but run their specific course. My impression from the cases I have studied in this area has been that there was no particular relationship between the release or liberation from incarceration and the development of symptoms. In the few reports we have of the onset of depression after psychic or somatic stresses, the latter are interpreted as precipitating factors rather than causes of the manic-depressive illness.

Surveys in which the course of manic-depressive psychoses have been followed for decades indicate that such "provocations" are of incidental importance only. In our experience, we found only two cases in which the onset of manic-depressive psychosis, or either phase of this condition, could be correlated with time of the persecutions. Von Baeyer's figures, however, show a greater number of cases having such correlation. Of our two cases, one was a woman who developed her first depression after four years of life on "illegal papers," and who after emerging from these extreme conditions, discovered that her entire family had been killed. Her psychosis developed into a pattern of relapses every nine months, with only brief periods of remission. In this case, the events of persecution may be regarded as an "essential contributory factor." This view pertains only to the manic-depressive psychoses, and not to reactive depressions. The reactive depressions tend to follow soon after the persecutions, but show no manic phases or other characteristics of the circular psychoses, such as symptom-free or hypomanic periods. In the typical reactive depressions, we find other associated symptoms, such as hypermnesia, anxiety dreams, "survivor guilt" (Niederland, 1964) phobic fixations, etc.

A difficult forensic problem is posed by the involutional psychoses and depressions. Kielholtz (1959) defines this group as characterized by the presence of hereditary taint, onset of the illness in the sixth decade, and freedom from the psychopathies and circular character-

istics. The conditions are chronic, resistant to therapy, and show a gradual transition into the senile dementias. There is a strong suggestion of organicity and "endogenicity" in this group. Nevertheless, Kielholtz has recognized a psychic precipitant in 74 per cent of his cases. He described the emotional factors mostly in the context of existential crises such as isolation, uprooting, emigration, destruction of families, and loss of social status produced by persecutions. Thus, even in conditions conceived as basically organic, the activity of psychogenic factors cannot be denied. On the other hand, I have seen two cases in which an involuntional depression evolved out of a chronic depressive reaction of a reactive type. Under these circumstances, even the basic organic etiology must be reconsidered because of the chronic physical stress produced secondarily by the long-standing depressive reaction.

DR. KRYSTAL:

I would just briefly like to note that the general idea which Dr. Venzlaff has stressed has also been quite clearly pointed out by other workers. For instance, Winnick and Eitinger in Israel compared a group of people who were exiled in Russia to concentration-camp survivors, and they found an interesting thing: the concentration-camp survivors had certain object-relation disturbances, certain depressive trends, and tendencies to guilt and regression no matter what the diagnosis was. In other words, it really did not matter in what particular group they were categorized. Perhaps a capsule summary of our experiences with survivors of Nazi persecution is that while the overall rate of schizophrenia is not increased, we find individual cases in which the psychic reality of the patient made the "flight into psychosis" inevitable.

I would now like to call on Dr. William G. Niederland to discuss Dr. Venzlaff's paper.

DR. NIEDERLAND:

Dr. Venzlaff's paper is a scholarly, lucid, and well-documented study of those clinical conditions which are categorized as psychosis, schizophrenia, psychoticlike or borderline types of illness and related mental disorders. I wish to congratulate the author on his clear and penetrating presentation of a most difficult subject, which I am sure

will rank high in the annals of our workshop. I wish, further, to express my appreciation for the great amount of study, information, and useful insight which it contains and which will be shared, I hope, by many here and abroad. We certainly are happy to learn from Dr. Venzlaff's paper that German psychiatry has come a long way from the rigid, static, and apparently so firmly (in reality, so dubiously) established principles of so-called classical psychiatry. It is in part due to the work of Dr. Venzlaff and his school that contemporary German psychiatry seems to have removed itself from the formerly rigidly held position of exclusively endogenous causation of psychotic diseases.

If I may address myself to the many complex, difficult, and as of yet unresolved problems inherent in these conditions, permit me to discuss with you first some points which, in my view, merit further consideration and clarification.

My first point refers to the question of the clinical position of schizophrenia as a psychiatric entity in and of itself. As far as present-day knowledge goes, the clinical concept of schizophrenia includes or appears to include at least a considerable number of psychopathologically and genetically not always uniformly established clinical pictures, which even so-called classical psychiatry designated and still continues to designate by different names and classifications. Following the original terminology and classification established by Kraepelin and Bleuler, we distinguish among the group of schizophrenias: hebephrenia, simple schizophrenia, paranoid schizophrenia, catatonic schizophrenia, schizoid personality, etc. If one explores these various groups and subgroups, as for example schizophrenia simplex and hebephrenia, the hereditary and constitutional elements, of which Dr. Venzlaff spoke in the early part of his paper, appear to prevail. (In this regard, Dr. Venzlaff made appropriate mention of the genetic studies by Kallmann and other geneticists.) However, in other forms of schizophrenia, especially in the so-called paranoid type of schizophrenia—precisely that group of psychotic illnesses which, according to my observations, seems to prevail most often among persecution victims—the situation appears to be different. In paranoid schizophrenia and certain mixed forms which are also often characterized by distinctly paranoid features, demonstrable hereditary and constitutional elements appear to play, if present at all, a subordinate or secondary role, at least in a great many cases. In

clinically exploring this group of psychotically ill patients, one finds frequently among them: (a) that the family history and general anamnesis do not reveal the existence of major abnormalities in the past, or even of major premorbid or prepsychotic traits; (b) that traumatic environment and influences play a much greater role in their development; (c) that psychotherapy is possible in many cases and successful in a number of them; (d) that even in the absence of methodical psychotherapy, chemotherapy, pharmacotherapy, and certain rehabilitation procedures (about which I will report later on) are often helpful and can be of great use to such patients; and (e) that even fully developed delusional systems and ideas and apparently also some bizarre and distorted mental formations expressed by our paranoid patients may contain or may be found to contain, on deeper exploration, a demonstrable clinically and genetically important kernel of truth. In order to illustrate this last point, which in a sense leads us to the core of the persecution experience with the implied forensic-psychiatric exploration so important in our survivor patients, I would like to present you with some material on the Schreber case (Freud, 1911), which was studied at a time when no one had seen traumata of a magnitude and severity such as we have seen and learned to examine in more recent times.

The Schreber case, a classical study of paranoid schizophrenia, was based on the patient's autobiography published in Leipzig in 1903. Freud recognized that the patient's idea that he was tormented by God really referred to his feeling that he was tormented by his father who was a famous orthopedist in Leipzig, and who invented and used a number of orthopedic machines, braces, apparatus, contraptions, etc. for his patients. Schreber, in his memoirs, spoke of God tormenting him by applying a head-tying machine on his skull. Freud understood that these delusions and somatic hallucinations had something to do with Schreber's attempt to deal with his feelings about his father, but did not go further in his inquiry into Schreber's persecutory ideas. A few years ago, in an attempt to find out more about Schreber's father, it was my good fortune to come upon a number of his books. The father, in order to promote a harmonious growth of the jaw and other facial structures, constructed a "Kopfhalter," a head-holder, helmetlike contraption, which he used on his sons. Fifty years later, when Schreber became ill, he wrote that God used such machines on him.

Schreber's father also felt that the children should stand and walk upright at all times. In order to insure this, he constructed various braces and machines, illustrated in his *Book of Health*. The Schreber children had to do their homework sitting in a brace in a straight chair, erect and shackled down. To prevent his children from having bow legs, the doctor constructed braces they had to wear on their legs as well. Preoccupied with the prevention of masturbation, Dr. Schreber invented various other braces, restraints, and ties which were applied through childhood and early development.

I have gone through some details in Schreber's hallucinations and delusions because the insights gained from this case can be applied to our current work as well. In many cases, there is a demonstrable nucleus of truth in the paranoid patient's ideas. It is our lack of knowledge, our poor insight (allow me to say, very often our ignorance) that prevent us from recognizing the kernel of truth in the system of delusional formations. With Schreber, it took 60 years to find out what he was talking about delusionally when he spoke of God doing all these horrible things to his body.

Our patients, our paranoid patients, our persecution survivors tell us their stories in fragments, in sketchy outline, often only in bits and starts. Many hours of listening, with empathy and compassion, may be necessary before the psychiatrist can solve the puzzle, that is, before he can read the "rebus" of the patient's fragmentary and fragmented communication. One characteristic feature of the Nazi persecution is that the experience cannot be communicated. Dr. Venzlaff mentioned that he listened for five or more hours to his patient, and as he listened and listened he began to understand the multiple, relentless, coercive, and torturous procedures used on the people in the concentration camps. He realized that such experiences, such extreme situations, are bound to leave permanent marks and scars.

Dr. Venzlaff's approach in relation to the traditional so-called classical psychiatry is an advanced one. Yet, he still appears to adhere to the idea that temporal relationship to the persecution is the basis of the restitution, i.e., the concept of the German compensation courts. The point is that a close temporal relationship is assumed to be presumptive evidence of a causal relationship. Now, if we look at Dr. Venzlaff's certainly well-studied and well-presented cases, we find that the discovery of "bridge symptoms" and therefore

the proof of a temporal relationship was just a matter of chance. For instance, let us take the case of the woman in Budapest—she was “in luck,” one might say, insofar as there was a doctor around who was later able to testify that when she was allegedly well and taking care of her whole family, she showed hypomanic excitement and delusions of persecution. However, most of the patients we see are more likely to have lived in a poor Hungarian or Polish farmer’s house, or in a pig sty, or in some other precarious hideout. Such a man would be most unlikely to find justice today in the German compensation courts because of lack of so-called convincing evidence.

If our paranoid patients tell us that they are afraid of an American policeman in the street, and they cannot go out in the street because they may be persecuted again, we can easily recognize their fears of renewed persecution, i.e., the return of the dreaded past. In the patient with more serious disturbances of ego function, the same fears may be presented as a delusion: e.g., that the policeman in the street, or any person with whom he comes in contact looks like a Nazi. He may develop this type of fear vis-à-vis the examining doctor, and he may feel, as one patient told me, that the doctor looks to him like Dr. Mengele of the Auschwitz concentration camp. Of course, the patient who experiences the medical examiner as Mengele will never reveal this to the doctor because of his fear of a new persecution.

I also wish to call Dr. Venzlaff’s attention to an error in his otherwise excellent presentation. The error occurs in his reference to the material by Dr. Kral. I believe that it is not Dr. Venzlaff’s error, really, but he mentions it—as it is done also in many German court decisions which deal with psychotics: they cite Dr. Kral’s opinion to the effect that there was no increase in the incidence of psychosis in Theresienstadt. Dr. Kral had been a psychiatrist in the concentration camp of Theresienstadt. Early in 1951, he wrote a paper about what he had witnessed there. You heard already from Dr. Venzlaff that Theresienstadt was a so-called “good” concentration camp, and Dr. Kral is often quoted as saying that there was no increase in the incidence of psychosis in Theresienstadt. It must be stated that in all this so-called documentation, Dr. Kral is misquoted. He states in his paper the following: “Jewish doctors in the concentration camp Theresienstadt, even though it was so much less deadly a place than Auschwitz and the other camps, knew very well

that if they diagnosed anyone as psychotic he would be shipped 'to the East,' which in those days meant euthanasia." To be shipped to the East meant that he would be cremated, incinerated. The Theresienstadt doctors, says Dr. Kral, would avoid making a diagnosis of schizophrenia in order to protect the schizophrenic patients from extermination. This is why there was no officially reported increases in the rate of psychosis or schizophrenia. The doctors tried to commit, in Theresienstadt, as few patients as possible to spare them the transportation East, that is, their being cremated, or buried alive, or exterminated by other barbarous means. Thus, I again refer to Kral, the low rate of schizophrenia in the psychiatric unit in Theresienstadt is explained by the fact just mentioned—that the psychiatrists simply hid the schizophrenic patients, avoided making the fatal diagnosis, but protected them and tried to treat them as skillfully as possible. It is remarkable that this report of gross degeneration of the German system of medical ethics and justice is still consistently misquoted in the interest (presumably an unconscious one) of perpetrating and justifying further injustice.

Finally, I cannot overlook another point made by Dr. Venzlaff, which seems to me in need of some further clarification. In referring to the effects of exhaustion he says: "Experience has shown that the effects of exhaustion usually have no influence on the endogenous psychosis." Dr. Venzlaff quotes, in this connection, certain conclusions from World War I, that "tolerance of the psyche to the effects of exhaustion may be regarded as almost limitless." This may or may not be so. But permit me to ask Dr. Venzlaff and all who have worked with him, if one can really speak here of exhaustion? When a man or a woman or a child came out alive from Auschwitz, or Bergen-Belsen, or Dachau, was this exhaustion? We know that the inmates were down to 70, sometimes 60 pounds. Was this exhaustion? Given these factors, is that word at all applicable? Wouldn't it be more appropriate to talk about dehumanization, bestialization, transformation of a human being into a creature without identity, without anything left of what we expect in a human being? One of my patients, a young man who was thrown into a concentration camp at the age of 12, and managed to survive Bergen-Belsen, drew a picture which turned out to be the image of the dehumanization, the "diabolization" (in that he was in the picture identified with Germany and the Devil), the utter dehumani-

zation he experienced. This patient's self-portrait showed the paranoidization or exhaustion of psychological resources which has become the permanent state of many victims of persecution.

DR. VENZLAFF:

I am afraid that Dr. Niederland misunderstood me. I said that although there have been reports that the somatic stress of warfare would not, by itself, be likely to produce schizophrenia, we are dealing here with a situation of such unprecedented existential crisis that it is a qualitatively different entity. Certainly, I agree that the destruction of home and family, degradation, and all the other things that happened to the victims of Nazi persecution are pathogenic factors of another order, capable of psychogenesis of schizophrenia.

GENERAL DISCUSSION

ALEXANDER SZATMARI, M.D.:

When one considers the psychological factors which are at work in the genesis of the schizophrenic process, it is imperative that one understand the role of ego organization in the pathological process. There are four common problems of every human being which must be securely, adequately, and safely satisfied in order to gratify the growing needs of human security.

Until recently, we were quite willing to believe that satisfactory ego development precludes persistent breakdown at a later age; however, the postwar years have suggested that this view is mistaken. Recent contributions disclose that severe ego regression may occur if the intensity of the emotional impact is high; and furthermore, aftereffects of this regression with a variety of consequences still exist after 20 years. To reconcile our earlier views with these diametrically opposed notions, one must be well aware of the mechanisms of the so-called late ego regression.

The synthetic function of the ego includes dealing with reality, with the everyday stresses and difficulties of life. If these stresses become overwhelmingly intense, and if they are prolonged, then the normal devices of the ego used in coping with stress tend to become more and more regressed in order to permit survival. Menninger

(1958) described five orders of defense against disorganization, the last two of which can be related to a psychotic ego regression. One must be prepared to accept the concept that the ego functions partly to make reality palatable, and that the ego must, at all times, encompass this reality in terms of its own experience, memories, or whatever, whether or not these have been gratifying or dangerous in the past.

In cases which involve the survivors of the concentration camps, it is obvious that the ego regression was so severe in some cases that it bordered on disorganization, so overwhelming were the stresses with which it was faced.

It seems from our experience that in the severe ego regression case the patient experiences the extermination of his fellows, the selections, the meaningless death of family and friends, all in terms of early infantile memories; these memories are not those maturing memories of the past, but rather the undeveloped memories of the primitive ego. In other words, the very early, infantile, long-forgotten and long-assimilated aggressions become reactivated, though obviously not on the conscious level. All the horror which the reality of the moment presents to the patient, therefore, is matched or met by the infantile aggressions and is unconsciously experienced as a "regurgitation" of the early aggressive fantasy now projected into reality. This must be considered as a factor with which the patient is unable to cope, and is most likely one of the origins of the so-called survivor guilt.

Normal psychoanalytic practice familiarizes us with the notion that, on an infantile level, the patient experiences the departure of his mother as a desertion and that the abandoned child is likely to feel that he has caused the mother to forsake him, because of his "bad" aggressive impulses—either as a punishment or by causing her destruction. As a result of the magical thinking due to the ego regression of our patients here, however, there is a tendency to view the death of mother, father, sister, or brother as their direct responsibility; the event is obviously viewed through the aperture of early infantile aggression. This happens again in many of the nightmares, where the guilt repeats and fortifies itself, maintaining the repetitive pattern of the regression. It can be considered as a dread of one's own aggressive omnipotent impulses, similar to the world destruction fantasy of the schizophrenic.

Another interesting point is the role of the missing grave. The burial ritual seems to be an important part of the mourning process, as is evident from many anthropological studies (e.g., Róheim). It seems quite probable that because there is no grave, death is not accepted, and the mourning is therefore incomplete. Often it takes a very long time before the death of one member of the family is accepted, and even then the deceased repeatedly returns in a pseudohallucinatory form.

DR. KRYSTAL:

Dr. Klaus Hoppe of Los Angeles, has pointed out, as have some of our contributors, that the problem of repressed aggression in victims of extreme cruelty produces a lifelong problem in handling aggression.

The problem of aggression is one of the most difficult areas in psychotherapy with survivors, insofar as the aggression occurred under circumstances so horrendous that it is almost impossible for the psychotherapist to prove to the patient that he did not "cause" the destruction and that his fantasies were not actually endowed with omnipotent power. As Dr. Szatmari pointed out, the circumstances of the persecution can be viewed as a seduction of the survivor into psychically participating in all impulses that he would have otherwise managed to repress or sublimate or deal with in more normal ways. There is no doubt that the persecution experience created a psychic situation in which infantile fantasies were revived and lent the feeling of reality.

MARTIN WANGH, M.D.:

I would like to make one point in relation to the so-called 'bridge symptoms,' which the legal authorities demand. We have to explain why it is that these symptoms are not always apparent. In Denmark, Thygesen and his co-workers examined concentration-camp survivors and found a very astonishing fact. Those survivors, who at the end of their concentration-camp experience had tuberculosis and were therefore hospitalized (under the social system in Denmark, this meant that their families were also taken care of while they themselves were hospitalized), in follow-up studies made 10 or 15 years later, showed a considerably lower rate of mental illness than

did those who, on their return to Denmark, immediately resumed their jobs or their education. What happened was that the survivors in the first category were taken care of and protected and therefore did not use up the available physical or psychic energy on the curative process; on the other hand, those who immediately tried to encapsulate, to cover up, to defend themselves against the breakthrough of their illness, after a time (five, 10 or 15 years) and under the normal stresses of everyday life, showed a greater weakening of their defensive systems and therefore broke down. But until this breakdown or, for instance, during the first years, they might well have been called the healthy ones, the ones who were suffering less from aftereffects, who had withstood the experience better, because they were working and not complaining to anyone. I think that this *appearance* of health is often deceptive. People who have extra strength may use that extra strength to cover up what might otherwise come to the surface.

The other point I would like to make is in relation to the question of who lags further behind—psychiatry or the legal profession? I think it might be said that the professions are running neck and neck here. The German Restitution Laws are certainly very much advanced in their principles of health indemnification. Unfortunately, these views are vastly ahead of the psychiatric understanding generally prevalent among psychiatrists in Germany—and not only in Germany but also among a good many doctors here in this country. Actually, however, the whole concept of evaluating the damage a person may have suffered merely on the basis of loss of earning capacity seems to me narrow and erroneous. Are we, in this fashion, giving consideration to the extent of the real damage? One can imagine—and I suppose those who have seen a great number of the survivors will have found among them people who have earned a good deal of money—people who may slave from morning to night in an attempt to work off their guilt for survival and for whom, therefore, earning capacity does not seem to be disturbed at all. But, what is disturbed is their capacity for the pursuit of happiness. The idea of the right to the pursuit of happiness—a most familiar concept to Americans—and thus of damage to the capacity for the pursuit of happiness, has not yet been given any consideration at all in the legal system which established the reparation laws, nor for that matter in the indemnification laws in this country. This is not

an accusation, but I do think it is a point which has to be made. A possible rectification would have profound consequences.

DR. KRYSTAL:

Dr. Tanay—in our second workshop—pointed out that the denial of illness caused the apparent absence of “bridge symptoms.”

Concerning the nature of the deficiency which is compensable one should try to evaluate disability in earning capacity, then social function, and finally the degree of suffering involved and attempt to form a “suffering index.” The exclusive concentration on the industrial capacity gives a totally inadequate means of evaluation of the aftereffects of traumatization. The amount of suffering involved in the claimant’s life is difficult to measure and is certainly not compensable in any form except by treatment and rehabilitation.

DR. TANAY:

There is a great discrepancy between what is meant by “schizophrenia” in Germany and in the United States. Frequently we make a diagnosis of schizophrenia here which would not have been made in Germany. I have seen many cases in which an American psychiatrist makes a diagnosis, very broadly and carelessly, the report goes to Germany. There either the reviewer or the court says, “Here is a University Hospital or court which testified to the fact that this individual is schizophrenic.” When the facts are reviewed it becomes clearly a moot question whether this person was schizophrenic or not. Either other diagnoses are appropriate or the clinical picture does not conform to any nosological entity. In Germany, this is then taken at face value and serves as a ground for denial of the claim.

Just recently, I had a case in which I had to prove that the gentleman who was taken by the German court as a psychiatric expert was, in fact, a general practitioner in the city of Detroit, who was called in by the court to sign a little paper and saw the patient for a few minutes only. In Germany, however, this was taken as positive proof that this person was a schizophrenic. My own more careful and extensive evaluation of the patient showed that we were not dealing with a schizophrenic.

The people who send reports to Germany are not aware of this

great discrepancy in the diagnostic criteria. Nor are the experts in Germany aware of our loose usage of the term "schizophrenia." I am not critical of this loose usage but I think we have to get together and understand what we mean by it. Then there is the problem of anxiety neurosis. If the Veterans Administration here declares: "This individual suffers from personality changes," he gets nothing. But if it is stated that: "He suffers from psychoneurosis, anxiety type, 80 per cent disability," he receives compensation. It is just the opposite in Germany. If we use Dr. Venzlaff's term, "personality change due to persecution," the patient is in good luck. I have to plead guilty to this myself. At first, I used the same tools that served me so well at the V.A., but I learned that nosological terms meant different things in various countries. By reading German literature, I did find out that psychoneurosis, anxiety type, is something entirely different; it is usually not compensable and is typically misunderstood as some kind of a distortion or attempt at extortion on the part of the patient. The words that we are accustomed to use lead to considerable misunderstanding. The organically oriented psychiatrist exerts all of his effort trying to make the correct diagnosis, but the diagnostic labels are imprecise, and mean different things to different people. We can gain better understanding and communicate better if we can describe what happened to the patient, how he has handled it, and how he was changed as a result.

DR. KRYSTAL:

Dr. Niederland has pointed out that schizophreniclike symptoms can be found in survivors who are not psychotic and in people in whom the total so-called process schizophrenia cannot be demonstrated.

HANS VON BRAUCHITSCH, M.D.:

There were two points in Dr. Venzlaff's paper on which I would like to comment. Neither one of them is directed in any way against Dr. Venzlaff or his paper, but rather against an attitude which makes it so exceedingly difficult to see that justice is done.

One of them is this problem which has been mentioned several times about the "bridge symptoms"—the temporal connection between trauma and overt collapse. It has been mentioned that there may not be a skilled observer available to notice the bridge symp-

toms. Their absence, in terms of gross symptoms, does not prove that the patient is really living a life which is worthwhile living. But even beyond that, I think that the little we know about the psychoses, and especially about schizophrenia, even if we are of the most conservative point of view of genetics which sees schizophrenia as an organic disease, or if we adhere to more dynamic schools, it is unscientific to think that schizophrenogenic trauma has to produce the gross syndrome immediately. On the contrary, we know from all our experience, no matter what point of view we take, that it does require a considerable time to appear. Whether or not we believe it is a hereditary disease (which I don't think many of us still do) the children are not sick from birth on—they will become schizophrenic at the age of 12 to 20, and there is a latency period. The psychodynamic view supports this idea. The early childhood trauma will not become clinically apparent until many years later. I think it is unscientific to expect psychosis which has been induced by massive psychic traumatization to become apparent immediately, and in temporal connection with the trauma. This expectation is contrary to our best knowledge of psychic function and illness.

In the work I did here on psychosis among immigrants, a very small percentage were political refugees or subjects of massive persecutions, but the thing I observed was that the breaking point came shortly after emigration, with the loss of familiar well-known psychological structures, especially the mother tongue. The confrontation of the immigrant with his isolation, the emptiness of his life, tended to precipitate the acute psychotic period. And just on the basis of case histories obtained from the patients whom I have observed, I think it would be very easy to find causal connections with the situation at the point of traumatization, without being able to show every step in the continuum, without being able to demonstrate that immediately after traumatization there was overt psychopathology. The psychological isolation was the "straw that broke the camel's back." The same situation is probably applicable in regard to the requirements that some kind of a somatic connection ought to be proven between traumatization and the psychosis. I consider such a requirement to be totally unfair. It would be superfluous to try to dispute whether certain schizophrenic forms of psychosis may have a more organic or hereditary basis, such as hebephrenia or schizophrenia simplex.

It has been said that paranoid reactions may be more reactive in nature. It seems to me to be mainly a matter of the individual's ability to retain his capacity for expression of feeling. There are those who are unable to express themselves, unable to abreact the original traumatizing situation, and who may develop symptoms of muteness and bizarreness. Some patients have even lost the facility of language to voice their feelings of persecution, of anguish. Casual observation is more likely to suggest a classification of hebephrenia, simplex, chronic and undifferentiated schizophrenia. These patients are worse off, not because their own psychosis was less connected to the original trauma, but because they are less able to cope with it.

In conclusion, I feel that the two concepts of forensic psychiatry—temporal connection and somatic connection—require complete revision insofar as they are completely out of step with all clinical observations.

WULF GROBIN, M.D.:

I am not a psychiatrist but an internist, so what I have to say here will have a different approach. It is very interesting to observe the results that I get back from Germany (I am referring to the decisions of the Restitution authorities). I have little difficulty in obtaining recognition of claims for organic disease, even of the most far-fetched type, provided I can establish that the applicant has the disease now and that he or she was in a concentration camp for a sufficiently long time. I am, of course, exaggerating somewhat. However, a patient who now has schizophrenia (and interestingly this is almost always of the paranoid in type) as proven by our psychiatrists, who is confined to a mental hospital, who has a history full of severe physical and mental suffering during the persecution period, satisfactorily confirmed by witnesses, etc., who has broken down at least five or six times in the intervening years, and who had additional physical disorders contributing to the psychosis—such a case might be rejected!

One case, known to Dr. Szatmari, where sterility had been a persistent worry to the person, who went through untold misery to try to cure that sterility, this case was rejected, with the explanation that schizophrenia is *Anlage bedingt*, i.e., hereditary.

It is my feeling that this kind of thing is really not entirely the fault of the German examiners; it is partly also the fault of our own

psychiatrists here, of our own doctors here, because such patients who arrived here in 1948-50 were diagnosed as schizophrenic with an inadequate understanding of their problems, and with no reference, or only a passing remark, to their experience in the camps in the doctor's notes or hospital charts.

I saw an asthmatic patient who is going to be seen shortly by a psychiatrist, and who has been going to an outpatient department of a Jewish hospital in Toronto for the last 17 years. On two occasions, social workers had even remarked that she should be referred to a psychiatrist. She was never seen by a psychiatrist. There is not a single entry in her entire chart about her past history—no mention of her concentration-camp experience.

ROBERT GRONNER, M.D.:

As a committee member of the American Psychiatric Association for Psychiatry in Medical Practice, I am familiar with what is going on. There is a deep ambivalence concerning the use of psychiatric tenets, and generally the psychiatrist is seen only as the fireman who comes in when it is too late.

I want to address myself to the problem of the "bridge symptoms," and I think a useful construct would be to use the psychoanalytic dream model. Thus, seen in the light of latent and manifest content, what may appear to be an absence of bridge symptoms is essentially the patient's attempt at adaptation—perhaps with some slight or not so slight characterological deviations—which he tries to maintain until he is overwhelmed by the latent pathology and becomes seriously disturbed. I do believe that the deficiency of the law is simply due to the fact that when it was written (of course I assume this), with the help of academic medicine and academic psychiatry, these professions were traditionally book-bound and unable to modify their views by listening to and observing patients. I have, personally, in well over 200-250 reports and examinations, simply side-stepped the issue of bridge symptoms whenever it was not possible to establish their presence. It is very difficult in a short examination to reconstruct the whole biography before and after the trauma, but I think I have had very few repercussions. It is possible to do justice. However, and this I think goes for the entire meeting, we do have, because of various deficiencies not only in the law but

in the philosophical stance of the authorities, to constantly compromise between what really goes on and can be evaluated and a genuinely scientific integrity. For instance, let us take the concept of predisposition. We do know it exists, but no sooner do we mention the word "predisposition," than we significantly reduce the chances of the claimant. Yet, the interplay between what there is and what is being done constitutes a very important scientific viewpoint; thus we actually have to compromise, almost corrupt ourselves, and this is true in many other facets of life.

Another example of this problem is the so-called *Renten-neurose*, that is, the compensation neurosis, which is always present. That it was created by the trauma itself, by the aggressive elements, by the massive regression, that it is in itself a symptom, the court and many psychiatrists do not understand. Consequently, we have to bypass it and sometimes I rather feel a certain loss of integrity.

DR. KRYSTAL:

Dr. Gronner is posing the extremely difficult but important question of the pressures upon the examiner, and perhaps "occupational diseases" of examiners. Not only is the psychiatric expert's integrity in jeopardy, as Dr. Gronner points out, but his emotional health as well. The stories which he hears, the people with whom he deals, are bound to provoke a strong emotional response in him. All of the descriptions of human degradation, abuse, and murder must be dealt with in his own mind. It can be done hygienically if it is handled consciously as one's mental material, a painful but necessary opportunity to discover the extremes of evil, and the depths of degradation of which one's human mind is capable. If this material is approached not with conscious self-awareness but with repression, the only possible alternative is to act out transferences. The failure to recognize the self-sameness of one's mental material is a failure of integration, which leaves parts of one's own mind in an "outside" status functionally analogous to projection. What we cannot own up to, we may have to reject in "others." Thus, the friendly, compassionate attitude which one regards as most helpful, may be replaced by anger, disgust, scorn, pity, or shame. The examiner who acts out his anger against the claimant is displaying a symptom of his own difficulty, as is the one who suffers from depression, or who

has the need to overindulge or seduce the patient. What I have said is, of course, well known, but we must be especially alert to this problem in dealing with massively traumatized individuals, such as the survivors of Nazi persecution, because of the extraordinary impact of their life stories and their present tragic malfunction.²

Our experience has been that with these patients, the examiner is especially likely to behave contrary to his role as a friendly, concerned individual, devoted to full understanding of the claimant, his story, and his present ability to function.

These patients come in with stories filled with every horror imaginable, with symptoms and actions which are likely to impinge upon every sore spot, every unresolved conflict the examiner may have, no matter how successfully he has kept it hidden in his contacts with "ordinary" people. Under these circumstances, the examiner is no longer able to empathize with the whole person of the claimant, but reacts to a part of the patient's story, behavior, or character. He may be driven to unconsciously identify with the victim or the aggressor. He may act out his anger or disgust, or indulge his reaction formation to these affects. He may scorn the persecutor or feel disgust with the vanquished. He may respond with paranoid attitude to either the persecutor or the victim. The examiner may take on the function of *judging* the severity of the patient's *persecution* and want to compensate for it, rather than restricting himself to evaluating the degree of disability, social impairment and suffering. This form of acting out on the part of the examiner is symptomatic in a number of ways. Insofar as he has changed his role from that of evaluator of the disability to that of judge of persecution, the examiner acts out an identification with the survivors who have an ambivalent hierarchy based on who suffered more (described in Chapter I). It is not proper for the examiner to compare any claimant with any other on the basis of what has actually happened to him. The basic tenets of dynamic psychiatry teach us to concentrate on the psychic reality of the patient, and upon the interaction of the patient's predisposition and personality with the psychological burdens imposed by the persecution, and the resulting handicap. It

² Note that in my saying "tragic," there is a sense of identification with the survivors, who felt that it is "unjust" that those who have suffered in the past should be suffering still. The use of this adjective may be a symptom of psychopathology that develops in this work.

is not the function of the psychiatric examiner to determine whether a patient is "deserving" of restitution or rehabilitation, nor is it within the examiner's province to "make up" to him for past miseries. Whether a survivor had been an informer, Capo, whether he preyed upon his fellow prisoners, or did other "bad" things, may be of moral or legal concern to society or his fellow prisoners and himself, but to allow such information to influence the examiner's decision about the present psychiatric status and its causes is clearly improper. To usurp such a Godlike role is not only outside the authorized function of the psychiatric expert, but, in fact, is an acting out of a countertransference which will be detrimental to the doctor's function and health. Yet, the impulse to play God is as ubiquitous as it is pathogenic.

The need for an empathic relationship with the claimant, necessary for adequate, insightful, humanistically animated evaluation, also creates pitfalls. It necessitates empathy, which involves partial conscious identification with the claimant. To "put oneself in the shoes" of a person who has been degraded to the point of cannibalism, who has been forced to submit to all possible abuses, whose survival has been dependent on regression to an animal existence, stimulates not only our reaction-formations but may make the burden of dealing with disgust, shame, anger, and horror almost unbearable. A common defensive reaction to such a shocking situation is to take refuge in the idea that made the persecution possible in the first place—the dehumanization of the claimant—and thereby experience him as a subhuman, inferior, and a verminlike creature. One finds the telltale reference to the "eastern Jewish" nature of the claimant in surprisingly many reports, echoing the deprecatory Nazi propaganda.

Another way to ward off the impact of these feelings is to minimize contact or intimacy in the relationship with the patient. Commonly this is done by conducting the interview in a "questionnaire" fashion; in some cases, auxillary personnel in the form of "history takers" were utilized by examiners. Thus, the expert made contact with a report rather than with a living person—a survivor of the most fantastic degradation and destructive machine ever invented by man.

Another variety of symptom behavior on the part of the examiner is a judgmental attitude to the story of the patient's behavior during the persecution. In it, the examiner tries to judge whether the

patient "should have acted as he did" during the persecutions, or ought to have done otherwise. The most malignant form of such judgmental attitudes is one in which again the examiner steps out of his role of a psychiatric evaluator and takes up the role of punishing the patient for past "misbehavior." Such are the examples in which the examiner states that the patient does not deserve a pension because his behavior in the concentration camp was already evidence of psychopathology, e.g., the girl who cohabited with an S.S. man; the man who submitted to homosexual relations or who became a Capo. The survivor is condemned for saving his life—the dead for going to their death without a desperate fit of rage. The hostile and judgmental attitude of the examiner is revealed when he labels such a person a psychopath and attributes constitutionality to the problem. With one arbitrary judgment, he ignores the extreme, virtually unimaginable stress that led up to and accompanied the action in question. In addition, such an examiner uses what he considers the claimant's past misbehavior to justify his present one.

If the examiner is not to act out his disgust with degraded, defeated, humiliated people, he must consider his impulse to judge as being a symptom of his own dysfunction when he finds himself singling out one specific form of behavior as so unacceptable that he regards it as "psychopathic," as evidence of essential evil of the victim, rather than the effect of persecution. In order to qualify as a psychiatric examiner for these people, one has to be able to imagine their psychic state after years of degradation, ghetto life, starvation, filth, disease, systematic murder, and decay brought about by planned corruption and demoralization. One has to imagine a person who has witnessed the destruction of his family, of his community, who has existed as a worthless prisoner in a concentration camp, in front of the crematoria, constantly mistreated in every possible way, and reminded many times a day that he is soon to be exterminated.

In general, the German restitution laws tend to support the examiner in his proper function. He is asked to describe the claimant's condition, the degree of disability, and his opinion of the causal relationship between the persecution and present symptoms. The law does not ask him to make a judgment as to whether the patient *deserves* a pension or not. It does not stipulate that he should match severe persecutions with proportionately greater compensation. To the extent then that the examiner usurps such roles, he is acting

in a way symptomatic of his own dysfunction. However, the mechanics of implementation of the restitution laws do threaten the integrity of the examiner. He is in a position similar to the Theresienstadt psychiatrist who, when he made the diagnosis of schizophrenia, was passing a death sentence on the patient. Since our opinions are reviewed by our German colleagues, their opinion of conversion hysteria as a fraud and of schizophrenia as congenital, creates special problems. The psychiatric authorities are given the power to attribute entire groups of syndromes of admittedly uncertain etiology to predisposition and hence unaffected by a genocidal attack. The outstanding example is our subject today: schizophrenia. As no single cause of schizophrenia has been proven, how can one be expected to *exclude* the influences of experiences which we know have greatly harmed nonschizophrenics? Are we to assume that having the predisposition to schizophrenia grants one the immunity to mental traumatization? And yet the law permits an examiner to state such an opinion arbitrarily without requiring that he account for the ways in which the claimant handled his psychological traumata which resulted from the persecution.

Here then, the situation which only asks the examiner to state his opinion without giving good and sufficient reasons for his reasoning encourages the examiner to fall into an authoritarian role. We know that the danger of the physician's becoming authoritarian is the patient's dehumanization. Our colleagues who participated in euthanasia did so with the authoritarian "detachment," and with an ego split which permitted them to have contradictory and irreconciled views on the value of the human individual. That psychiatric examiners in the postwar era are not totally immune from this sickening process is observable in the symptomatic behavior of some experts, who are able to write fine papers about the aftereffects of persecution but react negatively to most, if not all, claims they see.

The dialectics of the humane and authoritarian views tend to run parallel, in relationship to these people, with the organic and dynamic view of psychiatry. The problem is difficult because many of the "survivors" have a masochistic character problem which brings out sadistic impulses in the authority figures with whom they interact. They have the need to experience the examiner, who makes them recall the events of the persecution, as their enemy; indeed, in an

immediate transference, he is experienced as a new edition of an S.S. or Gestapo officer. The unconscious tendency to form an aggressive, authoritarian, degrading, or overindulgent countertransference reaction creates a special problem. In my opinion, it is necessary, for the welfare of the examiner and the patient, to be constantly aware of these countertransference reactions, and to the highest degree possible for the examiner to trace and analyze all associative ideas, impulses and patterns. Doing so is the antidote for acting out one's emotional responses to the patient in the ways I have described.

In view of the intrinsic difficulty of the situation, the potential harm in working with extremely traumatized individuals, and the need on the part of the patient to seduce the examiners into misbehaving with them, it is necessary that we safeguard this type of contact with all precautions.

DR. VENZLAFF:

I agree with the points made, especially by Dr. Niederland, that the theoretical difference concerning the conception of schizophrenia in German psychiatry and American psychiatry is based mainly on phenomenological grounds. I further agree that the group of schizophrenias includes a number of clinical pictures like: simplex schizophrenia, paranoid schizophrenia, and the other subdivisions. However, we have to look at the nuclear core of schizophrenia. I agree further that this continuum or spectrum is, on the one extreme, the group of paranoid schizophrenic illnesses, which can be understood in psychodynamic terms. There are many opinions in Germany, and this is mine.

Now, the bridge symptoms: In speaking of bridge symptoms, I do not insist upon a constant symptomatology but rather a continuum of the schizophrenic process and the establishment of psychodynamic links, which must not necessarily manifest themselves as psychotic symptoms. For instance, if a person does not succeed in his adaptation after the liberation, he would be diagnosed as having a mild bridge symptom. In the Schreber case, one could assume that although Schreber had such bridge symptoms but no psychotic or similar manifestations (bizarre behavior, abnormal thinking, etc.), he did show certain manifestations which I would consider as being among the bridge symptoms. This is my concept of bridge symptoms, which

is, of course, completely different from certain legal concepts which have crept into the literature.

Nomenclature in psychiatry presents a real problem not only in America but in other countries as well. If we could retract all the terms and all the diagnostic statements and terminology, and simply rely on what we feel and see and observe in the contact with the patient, then there would hardly be any differences—there would be understanding.

DR. GRONNER:

I want to make a remark with regard to the bridge symptoms. I hold, perhaps without being able to prove it, that these symptoms could be reconstructed in all cases given enough time and study and a good anamnesis. They are always there. Practically speaking, however, the examining renders this situation utterly impossible—and therefore we have no evidence. I am nonetheless quite sure, and I think it is likely that in Germany there is more potential evidence because they can hospitalize these claimants for several weeks and really go into the matter. We are currently getting evidence from people who are in psychotherapy and psychoanalysis, that during apparent symptom-free periods there are various disturbances in dreams and sexual function, as well as characterological changes often of a masochistic type but other kinds as well, frequently characterized by drivenness and intensity.

*VI. Carter vs. General Motors Corporation:
A Compensation Decision Based on the
Relationship of Schizophrenia and Emotional
Distress*

DR. TANAY:

The German Compensation Law, much like the compensation laws in the United States, does not define specific illnesses eligible for compensation; rather there is the concept of loss of function caused by traumatic experiences and lasting damage to health. The Germans have come to recognize the relationship between psychic traumatization and loss of function, and have enacted into law the principle that any individual who suffers a loss of function, primarily in the ability to work and to earn a livelihood, whether the loss of function is a result of psychic or somatic traumatization, has a legal right to compensation.

We frequently hear the accusation that the Germans have passed a liberal and generous compensation law, the meaning of which is perverted through administrative procedure, and that this is a malicious and deliberate effort to frustrate the victims of Nazi persecution. It is true that many victims of Nazi persecution are deprived of the benefits guaranteed to them by the German Compensation Law, but in my opinion, this is the result of outdated and outmoded psychiatric theories. This discrepancy between law and psychiatry is not unique to Germany; similar problems have been encountered in the administration of compensation cases under the Workmen's Compensation Law in Michigan and other states in the United States.

Many victims of the industrial system have been deprived of their benefits because of legal and medical backwardness. Even when

the law has been updated, psychiatry has lagged behind because of a theoretical frame of reference rooted in dogma which denies the possibility of a causal connection. Opinions and prejudices of the practicing psychiatrist are not altered with the same relative ease as the changing of a law. Is it reasonable, therefore, to expect a physician who rejects the conclusion that there is a relationship between psychic traumatization and lasting disability, to be charged with the responsibility of determining the extent of the damage?

Here in the state of Michigan we are fortunate to have an enlightened legal precedent set by the Michigan State Supreme Court in the now famous case of *Carter vs. General Motors Corporation*.¹ The Carter Case has been of far-reaching significance in the recognition that psychological disabilities are compensable.

I would like to call upon the Honorable Theodore Souris, Justice of the Michigan Supreme Court, who wrote the majority opinion in the Carter Case.

JUDGE THEODORE SOURIS:

The Carter Case was a landmark decision in Michigan, judging from the subsequent literature in the field and in other jurisdictions as well, in that for the first time a court of last resort recognized the compensability under a Workmen's Compensation Law² of disability caused solely by psychic forces. In Carter there was no physical trauma in the traditional sense.

In Michigan and in other jurisdictions, for many years compensation was allowed if there had been physical impact: the loss of a leg or breaking of the back. I refer to cases in which awards of compensation were made for psychic consequences of physical injury, but Carter was not of this kind. Carter did not involve physical injury as such. Instead, Carter simply had a mental breakdown, as we laymen would describe it. He was described by the only psychiatrist who testified in this proceeding (Dr. Lawrence Tourkow) as a paranoid schizophrenic. The history was thus:

Carter was an employee of the General Motors Corporation and had just returned to employment after a rather protracted layoff. He had a

¹ 361 Mich. 577 (1960), 106NW2d162.

² Michigan's Workmen's Compensation Law can be found at CL1948 and CLS1961: 411.1 et seq. (Stat Ann 1960 Rev. and 1963 Ann Supp. : 17.141 et seq.).

history, known to his employer, of what was called a "predisposition toward mental instability." In the course of his return to work, he was placed in a new job that was strange to him. He was required to move from his workbench 7 or 8 steps to a conveyor belt, where he was supposed to take a single hub assembly back to his workbench. There he would use a tool to smooth out the burr holes that previously had been made by other workmen. According to the standards established by the company, he then was supposed to place the hub assembly in a certain position on the bench, return to the conveyor line where he would take the counterpart of that hub assembly (they were male and female units) and return with the second unit to his workbench and perform essentially the same operation on it which he had performed on the first. He then was supposed to put the two units together and place them on another conveyor line where another employee would work with them. Carter was not skilled in his work. He apparently had difficulty maintaining the pace of the production line, doing the job as he was directed to do it. He was reprimanded and otherwise subjected to the "ordinary" indignities of production line employment for failing to maintain the pace of the job. Consequently, he hit upon a scheme that permitted him to save the time it normally would have taken to walk twice to the conveyor line and back to his work bench, by simply going there once and taking two hub assemblies at a time and returning to his bench. This would have been a rather imaginative and successful way in which to perform his work but for the fact that he could not keep the two different hub assemblies separate. He kept getting them mixed up. As a consequence, when he put them on the other assembly line, mixed up as they were, it caused trouble down the line, as a result of which his fellow employees complained to his foreman and his foreman, in turn, complained to him. And so, he was caught in this dilemma: if he did his job the way he was supposed to do it, he couldn't keep up; if he did it the way he devised in order to keep up, he confused the line and was reprimanded by his foreman.

The testimony that was introduced in the legal proceedings described this process in psychiatric language, and to me it meant that he was subjected to overwhelming pressures from this insoluble conflict, very strikingly similar to those I have heard described at this workshop which were imposed upon the inmates of Nazi concentration camps.

Our difficulty in the Carter Case was, in fact, that there was no visible missing leg or a crippled arm. Some years back, as a matter of fact almost 40 years before the Carter Case, compensable injury

was found in a woman who was working in a mill when electrical equipment went awry, causing flashes of light throughout the plant and resulting in mass hysteria among the working women who were surrounded by these lightninglike flashes, and consequently had emotional psychic difficulties thereafter. My judicial predecessors had no difficulty with that case because there was testimony, you see, of a single fortuitous event that could be described even on the cold, dehydrated, printed record. But in Carter's Case, what was there other than the normal, everyday, common work situation, which indeed hundreds of others in this very plant found not at all disabling? And so as I review the literature, the Carter decision marks, in Michigan and elsewhere, the first time in which an appellate court of last resort found a compensable disability based exclusively upon psychiatric testimony of the fact that a "normal" industrial work situation was emotionally unbearable for a particular individual, considering the nature of his own peculiar psychic reality.

Incidentally, as I indicated to you, there was in the Carter Case only one psychiatrist who testified. The General Motors Corporation, for reasons which I have never been able to understand, did not offer psychiatric testimony. Perhaps it was incredible to the Corporation's lawyers to believe that any court would award compensation for such "nebulous claims" as could be justified only by psychiatric testimony. In any event, they contented themselves with only a very minor effort at cross-examination. But had there been conflicting testimony by another psychiatrist in this case, our task would have been somewhat more difficult, and our decision would have been based, quite substantially, upon the hopefully good judgment and wisdom of the referee who heard the testimony of the real, live, flesh-and-blood psychiatrists.

I cannot pass up the opportunity to note that there is another similarity between the problems we faced in the Carter Case and the problems that apparently exist in compensating the victims of Nazi bestiality. It is a legal problem that affects you only incidentally, I judge: the problem of causation. Causation is an element of proof legally required to establish entitlement to compensation for injury, physical or otherwise. This is an area, I think, in which the disciplines of psychiatry and law have very much work to do before we can speak to one another with understanding. You are much more

concerned with finding all the possible causes, and therefore you are very cautious in attributing a key value to any single cause. Dr. Niederland, for instance, felt compelled to stress that Schreber's imposition of those strange devices upon his children did not "cause" the son's paranoid collapse 50 years later. Well, I'm not sure that in legal terms we would be so hesitant, certainly not in the context of the Carter Case. Judging from the very enticing comments that Dr. Niederland made, I suspect that there is much information about the problem of causation known to you and your colleagues which would be of great value to both my judicial colleagues and myself. "Causation" is a prime legal battleground today.

INTERNATIONAL PROBLEMS AND THE GERMAN RESTITUTION LAWS (Report of a Panel Discussion.)

DR. TANAY:

This is going to be a working seminar with all of us participating. Our resource people are: Professor Dr. Ulrich Venzlaff, who is an expert in forensic psychiatry and is also particularly well-versed in German compensation law; Mr. Donald W. Loria, an attorney in Detroit, who specializes in compensation law and who argued in the famed Carter Case for compensation of psychic as well as somatic damage; and the Honorable Theodore Souris, the Michigan Supreme Court Justice who wrote the historic Carter decision.

Of great interest to everyone here, is the recently published *Psychiatrie der Verfolgten* (1963) written by Prof. Dr. W. von Baeyer. In this book there is a chapter devoted to the differences in testimony of the evaluation opinions of the various experts. A particular case history appears in this chapter, which I would like to discuss very briefly, not only because it is indicative of the problems with which we are confronted, but because of the contribution in the case by Dr. Venzlaff. The case is described as follows:

A woman, 64 years old (at the time of the case presentation), was from Germany. She had completed her secondary education, and at the age of 20 had married a chemist and had two children. In 1932 she left Germany, partly because of the pressure of the forthcoming persecution, and went to France. She left her parents behind, and they were

taken to an extermination camp and killed. In 1941, her husband was "interrogated" by the Gestapo and as a result of this abuse he died. Then this woman escaped to Southern France with one child, and left the other child with some peasants. She was hidden for a long time; then her son was arrested. I will not describe all of the difficulties this woman had gone through. Following the war, she developed—stated simply—symptoms of anxiety neurosis and depression; she also had a facial tick. About 1956, when she filed her claim for compensation, she gave a very detailed description of her difficulties to the German compensation office (there was no German Federal Compensation Law at that time). She also included reports which stated how sick she was by the well-known and competent psychiatrists, Minkowski and Targowla. In 1960, a French physician described a 25% loss of ability to work. In 1961, she was examined for the compensation office by a German university clinic for the so-called "Obergutachten" and they gave the mental status report which went something like this:

Mrs. X is clear as far as her consciousness is concerned. She is oriented about person, place and date. She was able to give her history in very fluent German and there was no evidence of any kind of memory disturbance. Her intellectual accomplishments did correspond to her educational level. On the whole, she makes a somewhat depressed impression but she is quite active. Her complaints are general changes due to getting older [p. 360].

As we know from compensation statistics, social security statistics, etc., aging persons have these difficulties and claims are denied. In the same year, however, this woman made a request for a personal expert opinion by Professor Venzlaff who, after taking a detailed psychiatric history, did arrive at a description that confirmed the French psychiatrist's opinion. Then the author of the book from which we are quoting, Prof. Dr. von Baeyer, also examined the patient on behalf of the Compensation Office and confirmed Professor Venzlaff's opinion.

I am starting with this presentation because I think it is important for us to recognize that tremendous discrepancies do occur in the opinions we give as expert witnesses. On the one hand, the law has provided certain provisions and uses such an expert witness to fulfill these provisions. Now, to what extent do his own prejudices interfere with this task of providing an unbiased evaluation? I think this should be one of the issues that this group should consider.

DR. GRONNER:

Those who do this work have no idea of how successful or how adequate their compensation examination has been, because nothing is sent back to them. We simply have to assume that if it doesn't come back, it was all right. Out of about 250 reports, I have seen perhaps 5 or 10 returned for re-examination. As to the rest, I do not know what happened. I really do believe that some system ought to be established in which the long-distance examiner gets a report, a reply, or something, to let him know what has happened. I do the best I can, but I do not know how well it is being received.

DR. TANAY:

Your question is answered, in part at least, in Professor von Baeyer's work where he states in how many instances his opinion was confirmed. Out of 161 cases, 144 opinions were confirmed; in four opinions the Compensation Office granted a higher percentage of disability than he had given; and in three instances the percentage was lowered. Incidentally, this shows what tremendous influence expert witnesses (at least in Germany) have, if out of this group only seven were changed.

Professor Venzlaff, do you think you could give us a short description of how this whole structure functions in Germany and compare the role of the expert witness in this country with that of the expert witness in Germany?

DR. VENZLAFF:

When there is a question raised by the applicant of having sustained damage to his mental health which would affect his vocational capacity, then an expert in the country of residence is consulted. In some cases, these opinions are accepted; in others, they are evaluated by experts in Germany who make the recommendation to the Compensation Office. The percentage of those who are awarded compensation without a review by an expert in Germany varies from office to office. It also varies from country to country of origin of the report. For example, in Berlin, they gave 80 per cent compensation automatically, whereas in Düsseldorf or Trier, the figures might be different.

DR. VENZLAFF:

According to German criminal law if a defendant is not legally responsible, he cannot be punished. To test this, the court chooses an expert. The expert is not brought by the lawyer of the defendant nor by the prosecutor, but is chosen and paid by the court. The criminal is sent to a mental hospital or to a university hospital for six weeks of observation and evaluation. Then, the doctor goes to the court and gives his opinion. The court must follow the opinion of the expert, otherwise the court must take another expert. It cannot overrule the expert; it must have an opposing expert, if they do not agree with the first. The expert has the right of cross-examination, too. Only after the expert has rendered his own opinion, is he subject to cross-examination himself. The German courts are obliged, if there is any doubt, to send the criminal for a medical investigation. In all cases of murder, brain damage by war or accident, etc., it is mandatory that the accused be examined. The court has to prove the responsibility and if there is any doubt, there must be an investigation.

If the perpetrator, because of mental illness or temporary disturbances, was unable to recognize the rightness or wrongness of his actions, there is no criminal act. If there is mental illness found and he is a danger to the community, he is sent to a mental hospital.

MR. LORIA:

What if the determination has been made that he was not criminally responsible, but there is no continuing danger to the community?

DR. VENZLAFF:

He is free.

DR. TANAY:

As I understood it before, it is up to the court to determine if this expert's opinion is admissible. Is it?

DR. VENZLAFF:

The accused can bring all the experts he wants, but his experts have only the role of a witness.

DR. TANAY:

The expert that the accused brings in—can he express opinions, or does he only testify to what he has heard?

DR. VENZLAFF:

Yes, he can express opinions.

MR. LORIA:

As a practical matter of comparison, does the accused's expert witness ever supersede in his opinion over the court's appointed expert witness if there is a conflict? Is it possible? Has it ever happened?

DR. VENZLAFF:

Yes, I have done it myself. One year ago, I was the "expert witness" for a case. The expert of the court said the offender was responsible and I said he was not responsible; then I went to the court and the court followed my opinion.

The court has to be convinced by the expert. And if the court is convinced by the opinion of the expert for the accused, it goes along with him.

MR. LORIA:

What about the court's ability to disregard its own expert witness's judgment? Is it not bound by the testimony even though it is its own appointed expert?

DR. VENZLAFF:

It is not bound. They have to appoint another expert.

MR. LORIA:

What if he disagrees or refuses to abide by the other expert? Is he free to disregard it?

DR. VENZLAFF:

They cannot say he is responsible if the experts say he is not responsible. If it is an advantage to the accused, they can disregard the opinion; but, if it is to the disadvantage, they cannot—they must get another expert witness.

JUDGE SOURIS:

And all of this is handled in Germany within the regular legal framework?

DR. VENZLAFF:

Regular civil courts. The same basis as the civil law.

JUDGE SOURIS:

Would it not be possible for these courts to sit in America where there are witnesses, perhaps, where the claimant resides? If there had been a separate administrative tribunal, I would see no reason why they couldn't have their hearings right here where it would be physically easier to adjudicate these claims. Why couldn't the German tribunal sit in the embassy in Washington, or in the consulates?

DR. VENZLAFF:

I believe that is impossible, because one administration intended to send experienced German doctors to New York, alleging that the doctors in New York were unable to give the necessary opinions. But, this proved to be unfeasible because German doctors could not practice medicine in the United States because of licensing rules and laws; therefore, they could not act as "expert witnesses" in American courts.

DR. TANAY:

Judge Souris has implied a different solution. He suggests that German doctors come, sit as a tribunal, which would take testimony from American doctors who could cross-examine the claimant. Judge Souris is disturbed by the fact that there is no opportunity to cross-examine anyone. In the United States you cannot bring a piece of

paper to court as evidence, you must be able to cross-examine the writer of that piece of paper.

DR. VENZLAFF:

According to the laws of the United States, is it possible to hold a foreign court here?

JUDGE SOURIS:

I think they would try to assist it, because the sole purpose of the tribunal's visit to this country would not be to practice law, but rather to adjudicate the claims that are being made here. The same thing would be true, as I understand Dr. Venzlaff, of the doctors from Germany; they are not coming to treat, they are coming to adjudicate.

(Consensus of discussion was that this would be permissible.)

MR. LORIA:

As lawyers, we travel to Germany daily, representing clients in Germany, for the purpose of handling their business affairs either in this country or in other countries. As a matter of fact, we've done it with reference to business in Germany. I see no difference between lawyers doing that in Germany and German doctors doing that here. What they would be doing here, as I understand it, would be simply assembling the data that we need as doctors, and rendering it to the tribunal in Germany as valid medical judgment. I just don't understand what the objection would be.

DR. VON BRAUCHITSCH:

You may run into a law official somewhere in the local American Medical Association who doesn't really know what it is all about and just to be safe, he says, "No." I think that if an opinion is asked of the official American Medical Association, you may get an entirely different answer.

MR. LORIA:

I don't think the American Medical Association would have any right to give an opinion, or to object. The right to practice medicine

is decided by state laws, and expert witnesses are not challenged on the basis of being licensed in a particular state.

JUDGE SOURIS:

Their purpose would be limited to assembling medical data which would be used in Germany. This could not be misconstrued as practicing medicine.

QUESTION FROM AUDIENCE:

Wouldn't patients mistrust German doctors?

GUNTHER HENKEL, M.D.:

I have to disagree with you. I am German myself. I came over a few years ago. I have a large practice in Windsor, Ontario. The German consulate in Toronto asked me to do these examinations. The patients come to me and I don't know why they all want to stay with me. They know that I am German; I don't hide it. Yet, it is not because I put them into a very good category or anything like that; afterwards, they say they are not satisfied with their own Jewish doctors and I have a terrible time convincing them to please go back to their own doctors.

MR. G. LASTE:

From the practical standpoint, I must say that if this had not been brought up, I would have liked to bring it up. Call it psychological defense—I completely agree that without this preoccupation of mind the German doctors would be very good.

DR. TANAY:

The problem is that these patients are suspicious of everyone.

MRS. IRA AVRIN:

I don't agree completely. I think there is a difference. I think that I could convince them to go to you, but I could not convince them to go to a German doctor.

MR. LASTE:

Sometimes people withdraw after they have a lawyer. Once a lawyer phoned and said, "I don't want to go ahead with this case." I said, "Please do it. You know that this patient is disturbed. She withdraws—she doesn't want to have anything to do with you or the case—but please go ahead and just do it for her and handle her so that you can get her to cooperate." So, I think the suspicion and the inner resistance against German doctors would be immense.

MRS. IRA AVRIN:

I think that part of the problem is (I've heard patients say this) that they will choose a German attorney to handle their restitution affairs, even though they may be hostile to the German attorney, because he might know the laws of the land better and might be able to handle the situation better for them. This has been said time and time again.

DR. GRONNER:

A great many people will go to a German attorney, not because they love him or think he is better, but because of the continuation of the pathology of the concentration camp. This might actually be an advantage of ours, in that it brings out the pathology in the relationship. I have had occasion to observe all sorts of attitudes. I have been called a Nazi, even though I have been in this country for 25 years, and I am German-Austrian, and I am Jewish—so I can be all things to all people. In practical terms, if the pathology is being brought out, it is useful and pertinent information to diagnosis and evaluation. The examiner needs to see the kind and quantity of psychopathology the patient has. I would feel that the German team could get at this pathology, if they were trained to utilize this sort of data. In some ways, however, I have certain doubts in terms of actually damaging the claimants, because if there is real hostility toward such a team, or anxiety, they would actually very often damage their own case. The patient would not give them evidence, would not tell the truth and would withdraw. I've seen that. I've had some hostile claimants from whom it was very difficult to get any information.

DR. TANAY:

I want to shift from the discussion to something else which I think is very relevant, namely, the quality of the opinions and to what extent does the opinion, or let us say the identification, of the psychiatrist (the forensic psychiatrist—the opinion-giver) prejudice the case. You have just mentioned that this seems to be independent of nationality or identification with the suffering of the patient. In Israel, where you would expect the doctors to identify with the victim, you find their own professional identification prevails most of the time. Let me restate this. What I am trying to say is: the law has established a certain principle; however the forensic psychiatrist has his views about it. He does not operate within the framework of the law. Let me quote from *Psychiatrie der Verfolgten*: “The prevailing opinion in social and forensic psychiatry does question the illness meaning of traumatic and social neurosis. It questions first of all the causal quality of these experiences and, therefore, does not recognize compensation obligation in connection with these experiences.” Somewhere else in the same book it is stated that the German legislature has decided that there is a connection. Let me quote: “It is enough that a causative relationship between the damage to health is probable.” That’s enough. This is in contrast to the prevailing opinion of psychiatry in Germany. The work of men such as Prof. Venzlaff, von Baeyer, Paul, and Kisker is considered “new” and not yet generally accepted.

Now then, it might be asked whether a psychiatrist (let us apply it to a situation here in the United States) who does not subscribe to the measures of the “welfare state,” and who therefore thinks that workmen’s compensation is a big political farce perpetrated upon the state by some left-wing agitators (as I have heard it said so many times) should continue to fight for his principles. In point of fact, however, the question is whether his office is a suitable platform for this kind of activity. The same thing applies here. If a psychiatrist in Germany, on the basis of his scientific study, believes that these experiences have no relation to illness, should he use the courtroom to voice his opinions? The law has already been established; the courtroom is not a legislative inquiry.

ALBERT B. KERENYI, M.D.:

There have been reports over the last several years of three youths who were charged with the crime of painting swastikas on public property in New York City. It was suggested that these youths be examined by psychiatrists to determine whether or not they were competent. I remember a letter that a doctor wrote to a New York paper that said, "What kind of a psychiatrist will examine the case? Will he be a Jewish psychiatrist who was a victim of Nazi concentration camps? Will he be a Nazi-oriented psychiatrist, or will he be an objective psychiatrist?" I think that this points up your problem—that the values, the prejudices of the expert are still there, and he takes these with him in arriving at his conclusions.

DR. TANAY:

If someone is considered for being part of the jury where there is a death sentence possibility, they ask, "Do you accept the death penalty?" If he answers no, he is disqualified. You cannot be a member of a jury if you do not believe in a death sentence in a state where this is a possible verdict. The law assumes that there is a relationship between psychic trauma and psychic loss of function—then the psychiatrist comes along and says he doesn't subscribe to it. One could say, that's all right—but, don't come here, because what we discuss in this courtroom has already been settled in the legislature, and you cannot function in the framework of deciding a question about which you cannot consider both possibilities.

DR. GRONNER:

I think something has to be said about the sociology of American psychiatry—it is usually overwhelmingly not in favor of the welfare state. I think we have to keep in mind, however, one thing that I discussed with a doctor from Berlin—the tremendous power of what is referred to over there as "academic medicine" (i.e., how a man was taught) and more so in psychiatry, because it is, after all, the oldest art and the youngest science.

If you ask the opinions of 10 psychiatrists on one particular case, you are likely to receive 10 different opinions.

DR. VON BRAUCHITSCH:

Dr. Venzlaff made a comparison to be discussed here: the German law in cases of Criminal Court (now we are talking about Civilian Court). In either court, when the law and the court leans heavily on the local university clinics, and they commit the patient for a period of from four to six weeks investigation, then these clinics are really able to determine in a valid manner whether or not the patient is criminally responsible.

In spite of the fact that the patient is not seen in the clinic and is thus not personally examined by any of the psychiatrists, the German university psychiatrist will judge these cases of concentration camp victims entirely on the merit of written papers by the doctors of the German Consulate, the psychiatrist of the German Consulate, and the psychiatrist chosen by the patient himself. Even if all three of these papers are completely objective, it can happen that one or the other does not devote enough time to it. Sometimes I have seen reports of a completely competent psychiatrist, but because he is not familiar with these special cases and these special problems, the report does not cover all the angles of these very complicated cases. Therefore, in Germany (where they have no opportunity to examine the patient) the case may be denied because the doctor's paper seems not to favor the client. This is one of the greatest difficulties which one can find in the handling of these cases—that the German psychiatric experts have no opportunity to see these patients personally. In other words, when the judge leans on one or the other expert, he just doesn't know anything about the patient; he knows only about the papers.

JUDGE SOURIS:

How does the judge have any information contrary to the information that, say, Dr. Tanay would submit about the patient, since the patient has never been examined by the German physician? How can he decide anything different from what Dr. Tanay, who is the only person familiar with the case, says?

DR. VENZLAFF:

There is also a doctor in Germany who passes judgment based upon what Dr. Tanay has written.

JUDGE SOURIS:

But he has never seen the patient.

MR. LASTE:

This is the way it's done and that's why I am intrigued by this possibility of bringing over a German team, not only a German team of psychiatrists but also a tribunal of adjudicators. So that, even recognizing the psychic problems that would be involved, it would seem to me that you would be getting a better professional judgment from the German psychiatrists than they are now rendering, based only upon opinions and the scant facts included in most of the psychological reports that I have seen.

JUDGE SOURIS:

In the American courts, we have a principle, a doctrine—we cannot overrule the findings of fact made by the trial judge, who actually saw and heard the witnesses, unless there is fraud proven or unless there is complete absence of fact in the record to support the finding of fact. Yet, these cases, which are very important to the claimants, are being ultimately adjudicated (if I understand the process accurately), on the basis of German psychiatric judgments that are not based upon personal observation, that are not based even upon a judicially made record of fact, but are based solely upon the documents prepared by American psychiatrists, which may or may not have a complete or even an accurate statement of facts. This is very disturbing.

DR. GRONNER:

It is worse than that, because there are German psychiatrists in Germany who render an opinion about a claimant who has never been examined by a psychiatrist, just by the general physician or internist, who makes the statement “anxiety neurosis” with all the rather incompetent documentation that allows for this diagnosis. Then the case is seen, merely on the basis of this insufficient material, by the university psychiatrist in Germany. Of course, it is not allowed and subsequently comes back as a law suit.

DR. TANAY:

I would like to comment on what Justice Souris said. Evidently this is not a principle, at least in this instance in German law. I will give you an example: not long ago I saw a case sent to me by the Consulate. They didn't agree with my opinion and required a new expert—a reevaluation. So, they directed that my evaluation be reviewed by another expert here in town. They appointed another doctor, an assistant professor in the Department of Neurology who is not, in my opinion, an expert in psychiatry; nevertheless, he was appointed. This was only to review the record, not to examine the patient. The claimant was represented by a lawyer who created a great deal of fuss about this, pointing out that the particular individual who was appointed was not an expert, therefore could not be used. So then the case came back to me to review my own report. If the patient did not have a lawyer in Detroit, the case would have been overruled by an expert in neurology.

JUDGE SOURIS:

When the German Consulate here appoints a doctor or a psychiatrist to examine a claimant, the German government is not bound by the opinion of its own expert. This is what bothers me, in terms of the legal implications involved. Even the government-selected psychiatrist is subject to reevaluation. Is that correct?

MR. LASTE:

I think basically this is correct; a reevaluation can take place. But I might say that the statements sent back to Dr. Feuer by the judges are very often accurate and fair. The negative impact of the cases turned down, which represent a minority of claims, are given excessive emphasis due to the whole complex.

MR. LORIA:

One of the problems that I have not heard discussed is a basic one which I think should be investigated: that is, the effects of compensation on the victims. I have read certain material which indicated that compensation benefits may be emotionally detrimental for some

victims and beneficial for others. I think a knowledge of the general effects would be significant in deciding where we go. If it is detrimental, we should adopt a different point of view. If it turns out that the compensation is beneficial, then I would suggest certain things that may help in terms of the problems that have been discussed.

It has been my experience that the truth of the existence of certain conditions is always a problem. It has been a problem in this country, particularly in regard to the matter that we have been discussing. I think that there are certain features in common in proving any kind of case, and that is the difference between objectivity and subjectivity.

In the problem of the emotion, there has always been a problem of truth. There has always been a fear of fraud when emotions are being compensated, or damage to the emotions is compensation sought. The historical situation in this country insofar as compensation for damage to the emotions is concerned has been very reluctant, starting only when there has been a verifiable objective accident which caused, for example, a fracture of some extremity that led to certain emotional consequences. The accident and the fracture were verifiable; therefore, there is some basis for granting compensation. A step removed from that situation would be the compensation which is granted when there is no actual organic pathology, but where there is a definite fact of a verifiable single traumatic event—some basis of objectivity—although that is a much more difficult condition to prove. And finally, there is the general situation where a series of stresses have caused some emotional repercussion. This is the least verifiable, the most difficult, and the least acceptable by the courts. It is my feeling that we are involved in just such a state of affairs in the concentration-camp situation.

I think it takes time for the courts and the psychiatrists to come to these conclusions. I think that the problem is further compounded by the fact that we are brought up to think in terms of blame and fault as being applicable to workmen's compensation and the concentration-camp situation. If we could remove from our thinking the concept of who is to blame, who is at fault, and merely try to scientifically observe the cause and effect relationship to events and consequences, we could approach a more accurate kind of result.

The second and last point that I would like to make is in regard to classification. Classification is and always has been difficult in the field of emotional illness. I have never found any classification which to me had real, absolute validity. I think that if we could talk in terms of symptoms of problems rather than in terms of classifications it would help the doctors in this country and the reviewing authorities in Germany. If that could be worked out, we would talk of the problems in living rather than in terms of psychological classification.

Finally, I would like to suggest that perhaps this tremendously valid kind of workshop which has been going on here might be taken to Germany. I think that if we could bring our viewpoints there, it might help to eliminate a lot of failures.

Summary

DR. TANAY:

In this group, although we did not have any formal presentation, we were very fortunate to have participants who had a great deal of experience: Judge Theodore Souris, Donald W. Loria, and Professor Dr. Ulrich Venzlaff. With the exception of the latter, the speakers have not had much experience with compensation for the Nazi atrocities, but they do bring with them rich experience in general liability and compensation laws.

In our session, the difference between German forensic psychiatry and American forensic psychiatry were discussed. Of importance to us are some differences in the court systems which have been brought to light. You, who write the reports, have to understand how these reports are interpreted, how they are processed—and this was supplied to us by the representative of the German Consulate here in Detroit.

Judge Souris suggested that in the interest of attaining justice, German teams or a German tribunal come to the United States, where the majority of the survivors are located, and conduct their investigations. Thereby, they could accumulate more information, have access to the individuals, and the claims could be made in person. There were some objections raised to this proposal. For example, in terms of examination by German psychiatrists here, there was the feeling that many of the claimants might have antagonistic feelings toward German psychiatrists.

There were a number of interesting observations made, such as the differences between various psychiatrists who render opinions. This not only applies to American psychiatrists but to various German psychiatrists as well. The psychiatrists in Israel were described as *the* disciples of the "old-time" psychiatry, the descriptive type of psychiatry. It was brought out that many people residing in Israel preferred to go to Germany, where they obtained a more dynamic evaluation than they could receive (at least at that time) in Israel. Thus, the problems we encounter here are not so much in terms of country, but rather in terms of the various levels of psychiatry—the developmental stages of psychiatry—if you will.

The problem of emotional reaction, sometimes countertransference of the psychiatrist, has a great deal to do with the results. The psychiatrist might not subscribe to the philosophy of the compensation law and through his evaluation achieves his purpose of sustaining his philosophy. This would represent a prejudice rather than a countertransference reaction.

The relative merits of the "expert" system as compared to the "adversary" system were discussed. It was felt that in the case of the survivors of the Nazi persecutions, the emotional reactions of the examiners and the adjudicators are extremely complex and difficult. On the one hand, there are frequent reactions of sympathy with the survivors who continue to suffer even 20 years after their liberation. This fact offends one's feeling of justice, but the attempts for restitution become even more complex, when we start to consider rehabilitation as an essential part of restitution. On the other hand, we obviously run into "experts" who, though they talk about fair judgments, consistently refuse any and all claims that come their way. Obviously, either extreme indicates an emotional handicap to the examiner.

Mr. Loria's comment that we should be more concerned with the loss of function, rather than the diagnosis as such, is, I think, an extremely important contribution.

VII. The Survivors of the Hiroshima Disaster and the Survivors of Nazi Persecution

DR. KRYSTAL:

It is our fervent hope that we can study *various* populations and circumstances which are involved in massive traumatization. Today we are fortunate to have with us Dr. Robert J. Lifton, who has studied two different groups who were massively assaulted: (1) the American brain-washed prisoners-of-war in Korea, and (2) the survivors of the atomic bombing of Hiroshima. Those of us working with concentration-camp survivors and other victims of persecutions were astonished to find that the psychological aftereffects of such disparate situations had an amazing number of similarities and parallels. I do hope that we can consider many different groups, until one day we can reach some valuable generalizations that can apply to the understanding of traumatized individuals.

OBSERVATIONS ON HIROSHIMA SURVIVORS

ROBERT J. LIFTON, M.D.:

In a way I feel saddened before this audience, in which all of you individually have shown courage in immersing yourselves in the concerns of concentration-camp survivors, to bring still another horrendous kind of experience to your attention. As Dr. Niederland joked at lunch, "I've been through Auschwitz and Bergen-Belsen in my work, do I need Hiroshima and Nagasaki too?" It's a good and a fair point, although his subsequent feeling was that in a way there was value in comparing them, as Dr. Krystal suggests, and I think that those of us who have worked from either side of the problem

have had the sense of a convergence of significance and of common findings in both, especially if we want to discover the deepest and most consistent psychological patterns of the survivor of various kinds of extreme experiences.

I am going to divide this presentation into three parts. What I will try to cover, though, in these three segments will be: first, a little about the Hiroshima experience itself, with which some of you may be familiar, the general outline of it, particularly its long-range effects; second, some generalizations on the question of the survivor, which have grown out of the Hiroshima research and which contain certain parallels to the concentration-camp situation, with regard to some matters that have already come up; and third, some thoughts about death and death symbolism, which is, of course, essential to the study of Hiroshima.

I will tell you a little bit first about my having become involved in this work in Hiroshima. I spent six months in Hiroshima after being in Japan for two years prior to that. I have done a lot of work in Japan over the past 10 years, but I had done two years of study of Japanese youth prior to going to Hiroshima itself. Originally, I had not gone to Japan with the intention of doing that study; I became interested in it and had been previously interested in related problems. I decided to stay on for six months more and do that study, which, happily, was the kind of research position which enabled me to proceed with the work at hand.

I found very quickly, of course, that problems of death symbolism entered into it in every sense in every level of the work. I also found, as I think about it now, that there is almost a direct relationship between the individual and the larger historical event in these matters. It seems to me that the more significant, the greater is the historical event for mankind in general, the less understanding we seem to be able to have for it—the more we resist comprehending it. I have the sense that after about 20 years now, some wave of understanding of perhaps a humble kind, a limited kind, is beginning to evolve concerning both Hiroshima and Nazi persecutions. It is only the beginning and I think that this understanding has enormous value not only for psychiatry but for our historical future as well.

I conducted this study over a six-month period, from April to September, 1962. I worked with a group called “hibakusha.” “Hibakusha” is a Japanese-coined word which means a little bit more than

simply one who's been through the bomb; it means "explosion-affected person" in literal translation. A little bit more than simple exposure and a little bit less than actual organic damage. It suggests something in between these two conditions. I chose to work with two groups of so-called "hibakusha," 33 chosen at random from an enormous list at the Research Institute at the Medical School in Hiroshima, and 42 survivors who were simply selected because they were articulate—they were doctors, city officials, writers, university professors, people who could express themselves, with particular knowledge, also leaders of survivor organizations.

There are officially in Hiroshima, for medical-legal purposes, four groups of people who are categorized as "hibakusha." The first group, of course, are those who were in the city at the time of the bomb—that is an area then defined as within about 4,000 meters of the hypocenter, up to 5,000 meters in some places. The second group are those who were not in the city, who came into the city within 14 days into an area near the center of the city. A third group were those who were engaged in aid to or disposal of the victims at various stations that were then set up. A fourth group were those who were *in utero* at the time and whose mothers fit into any of the first three groups. Of course, you can see that all four groups are those who were significantly exposed to radiation effects, which is the crucial aspect of the atomic bomb experience.

Of course, a considerable amount of background material had to be gathered. I interviewed everybody I possibly could in Hiroshima—mostly Japanese but other nationalities too, e.g., many Americans working there—about anything that I could learn about this whole 17-year interval. I was interested not only in the bomb itself but also in what had happened in the city, which was a psychosocial constellation of events.

I might mention that by this time I had learned to speak some Japanese and could conduct much of my work in Japanese, but for the actual psychiatric interviews, I always required an assistant with me. I saw most people for two two-hour interviews, some for longer, for three or four times, in order to at least get the outlines of the experience.

I might also say that this is a delicate issue for an American psychiatrist to be studying—the effects of the atomic bomb in Hiroshima—and I was well aware of this. I always had to work through Japanese

colleagues. My previous experience in Japan was, of course, a great help.

I would go out to visit the survivors at their homes with a Japanese social worker from Hiroshima University. The social worker would first present his card, which came from a respected Japanese organization, and then I would present my card. I would talk to the survivor, or family member if the former wasn't there, and would explain that my hope was, in conducting this study, that I in some way would contribute to the mastery of these weapons and hence to peace. I would just say that very simply. Of course, I felt this very strongly and it was crucial for getting the cooperation in this kind of study, because the possible antagonism and ambivalence are legion.

I wrote about this work originally in my first papers, describing the overall atomic bomb experience as being what I called a permanent encounter with death, which has four levels of sequential aspects to it; I will now try to describe these levels to you rather briefly.

The first of these four stages is the overwhelming immersion in death, directly following the bomb's fall, beginning with the terrible array of dead and near-dead which the survivor found himself in the midst of at that time. Of course, very important here is the sense of total unpreparedness which, as you know, is crucial in the disaster experience, and survivors were unprepared on many levels. It so happened that an "all clear" signal had sounded just a few moments before, so they were unprepared on that level. They were unprepared because of the deeper psychological sense of invulnerability that we know people have even in the face of imminent disaster. Incidentally, Hiroshima had not been bombed prior to that period of time, and the people had almost a magical feeling about this. Either they thought it was magically protected, or they thought it was magically dangerous—that something especially big was about to happen, as indeed, unhappily, it did. In any case, people had no way of anticipating the unprecedented dimensions of what was to happen. There was no possibility of previous experience lending the imagination the capability of foreseeing or anticipating what was to happen. In this sense, perhaps, it is impossible to be prepared psychologically for a nuclear disaster.

The number of deaths from the Hiroshima experience is still unknown. They are estimated, with great variation, from 63,000 to

240,000 or more. The official figure is 78,000. The city of Hiroshima estimates 200,000. There is just no relationship in these figures. There are many factors entering into this confusion, including the enormous chaos at the time, but also emotional factors which affect the estimators from all sides.

But the point for us here to begin with is that anyone exposed relatively near the center of the city could not escape from a sense of ubiquitous death around him, resulting from the blast itself, from radiant heat, from ionizing radiation.

I don't have time to go into more detail about the distances and the mortality within the various distances, but there was this enormous aura of death which encompassed the entire city from this one single "baby" bomb. Therefore, the most significant psychological feature, at this point, was the sense of a sudden and absolute change from normal existence to an overwhelming encounter with death. I can just illustrate that briefly from the things that some of these survivors when I interviewed said to me and from what they stressed as their earliest recollections. Of course, there was room for distortion 17 years later, but reading some of the literature of what people said and wrote immediately after the bomb proved to be amazingly similar. There is an element of the imprint that allows it to remain vivid and accurate, even for a 17-year-long interval of that sort, and it was 17 years after the event that I did the study. Some of the survivors said to me, "My first feeling was, I think I will die" or "I was dying without seeing my parents" or "I felt I was going to suffocate and then die, without knowing exactly what had happened to me." Those are typical expressions. But beyond the sense of imminent individual death, was the feeling of many that "the whole world was dying." A science professor put it this way (he was buried under debris), "My body seemed all black. Everything seemed dark, dark all over, then I thought the world is ending." I'll come back to this imagery of the end of the world—it's of great importance psychologically. Another was a Protestant minister who was himself injured but saw many horrible sights as he walked through the city. He said, "The feeling I had was that everyone was dead, that the whole city was destroyed. I thought all of my family must be dead, it doesn't matter if I die. I thought it was the end of Hiroshima, of Japan, of human-kind."

At this time, rather than the wild panic that we often imagine

(that's often the fantasy of those who imagine rather than experience it themselves), most described a kind of ghastly stillness and a sense of slow motion. Low moans from those who were incapacitated and the rest fleeing, but usually not rapidly, from the destruction, often toward the rivers which run all throughout Hiroshima, where there were thought to be family members or authorities or medical personnel, or simply where there were thought to be accumulations of people of any kind. This conveyed a feeling of death in life. You can see again immediately some of the similarities of what we have been thinking about in relationship to concentration-camp survivors too: a feeling of death in life.

I will read one passage that conveys this, as one store clerk expressed it to me. He said:

The appearance of the people was—well, they all had skin blackened by burns. They had no hair because the hair was burned. At a glance, you couldn't tell whether you were looking at them in front or in back. They held their arms bent forward like this (he demonstrated) and their skin, not only on their hands but on their faces and bodies too, hung down. Wherever I walked, I met these people. Many of them died along the road. I can still picture them in my mind, like walking ghosts. They didn't seem to look like people of this world. They had a special way of walking—very slowly; I myself was one of them.

Here you see, in this imagery, the classical picture of a ghost in Japanese folklore. Walking ghosts—again, the image of death in life; and you have the immediate and total identification of the survivor with those walking ghosts—with death itself. Many expressed similar emotions in relationship to imagery of Buddhist hell.

The psychological significance of this early immersion in death involves the element of extreme helplessness in the face of threatened annihilation, and this fear and anticipation of annihilation truly dominates the first phase. When we ask what it is that the survivor or the "hibakusha" fears will be annihilated at this time, he fears, of course, the annihilation of his own self, of his overall organism as he symbolizes it, and also of the world of people and objects in which he exists. The annihilation of the field or context of his existence, comes very close to what the existentialists mean when they speak of being-in-the-world, while at the same time reminding us of recent psychoanalytic work of the significance of the nonhuman environ-

ment, the annihilation of which is also anticipated at this time. Finally, he fears the annihilation of that special set of feelings and beliefs which relate uniquely to him and make him the specific person he is, or what we have come to call, after Erikson, his sense of inner identity.

This experience would have been so overwhelming, I believe, that many would have undoubtedly been unable to avoid psychosis; perhaps no one in the middle of the experience could have avoided it were it not for the extremely widespread and effective defense mechanism which I call "psychic closing off." (I referred to this phenomenon as psychological closure in earlier writings, but that became confused with certain phrases in "Gestalt" psychology.) What I mean by this is that in the face of grotesque evidence of death and near-death, people sometimes, within second or minutes (it is an immediate reaction), simply cease to feel. They will have a clear sense of what is happening around them but their emotional reactions are unconsciously turned off. A physicist expressed this by comparing it to an overexposed photographic plate, which is a useful kind of imagery. And another man who witnessed others dying around him at a first aid station said that he reached the point where "I just couldn't have any reaction. You might say that I became insensitive to human death," which is exactly what happens. A woman writer stated, "A feeling of paralysis simply came over my mind." This is the pattern of psychic closing off. The unconscious process taking place is that of closing one's self off from death itself, and the controlling fantasy here is, "If I feel nothing, then death is not taking place." It is, of course, related to defense mechanisms of denial and isolation, and also to the behavioral state of apathy, but I think it deserves to be distinguished from all these in its sudden global quality and its throwing out of a protective symbolic screen which enables the organism to resist the impact of death—that is, to survive psychologically in the midst of death and dying. I think it may well represent man's most characteristic response to catastrophe—at times life-enhancing, even, psychologically speaking, life-saving, but at other times, particularly when prolonged and no longer appropriate to the threat, not without its own very severe dangers. Psychic closing off, as effective as it is, has its limitations and it is immediately, in a way, resisted by the impinging stimuli both from without and within; those stimuli from within are expressed in the nature of self-

condemnation—that is, guilt and shame. The immediate need which survivors feel is for justifying their own survival in the face of others' deaths. I think we must say that this rapid experience of self-condemnation intensifies the lasting imprint of death created by the early phase of the atomic bomb exposure.

An important aspect of all this is a type of memory which I have referred to as the "ultimate horror," which symbolizes the relationship of death to guilt—a specific image of the dead or dying with which the survivor strongly identifies himself and which evokes in him particularly intense feelings of pity and of self-condemnation. Often these expressions of ultimate horror involves women and children who are suffering and dying in very miserable ways, because women and children are the symbols of vulnerability and purity in any culture, especially in Japanese culture.

There was one particular form of this ultimate horror which many of the survivors conveyed to me, and that was the recollection of requests of the dying which could not be carried out. Most specifically, in many cases, the pleas of the dying were for a few sips of water. Water was withheld from them not only because of the survivors' preoccupation with saving themselves and their families (and that was their preoccupation), but because authorities spread the word that the water might have harmful effects on the severely injured. In any case, the requests for water by the dying, in addition to reflecting the latter's physical state—perhaps a state resembling surgical shock—has special significance in Japanese tradition, as it is related to the ancient belief that water can restore life by bringing back the spirit that has just departed from the body. That means that these pleas were as much psychological expressions of the belief as they were of physical need. Indeed, one might say that they were pleas for life itself. The survivor's failure to acquiesce to the victim, whatever the reason, could thus come to have the psychological significance for him of refusing the request of another for the privilege of life, while he himself clung so tenaciously to that same privilege.

The second encounter with death is that which I refer to as "invisible contamination." In brief, this was the sudden outbreak, unexpectedly in an enormously mysterious way, of the symptoms of acute irradiation. These are very widespread; they involve nausea, vomiting, every form of hemorrhage into the skin and internal organs, and from the various orifices of the body, various lesions,

gingivitis, and a variety of symptoms including loss of hair on the scalp and other parts of the body. Oddly enough, this depilation was the symptom that seemed to create as much horror as anything else, even though it was relatively minor compared to some of the organic implications of the other symptoms. A serious complication was low white blood cell counts (severe leukopenia) which in many cases followed a progressive course till death. These symptoms of irradiation, which occurred sometimes within 24 hours or even a lesser time—sometimes a few days or a few weeks—were very irregular in their occurrence.

I will mention three rumors which swept the city of Hiroshima right after the bomb fell and which have, I think, great importance for both later effects and for general death symbolism. Related to the latter was the notion that everyone who had been in the city would be dead within three years.

But there was a second rumor which was even more emotionally and more widely held and that was that trees, grass, and flowers would never again grow in Hiroshima. From that day on the city would be unable to sustain vegetation of any kind. Here, the psychological message was: nature was drying up altogether; life was being extinguished at its source; all this suggesting an ultimate form of desolation which not only encompassed human death but went beyond it.

The third rumor related to the first two I mentioned: that Hiroshima would be uninhabitable for 70 or 75 years; it would be deurbanized, devitalized, and lose all of its life-sustaining capacity.

We may summarize these psychological aspects of the second encounter as fear of epidemic contamination to the point of bodily deterioration, a sense of individual powerlessness in the face of an invisible, all-enveloping and highly mysterious poison, and a sense, often largely unconscious and only indirectly communicated, that this total contamination must have a supernatural or at least a more than natural origin; that it must be something in the nature of a curse with which one's group is afflicted as a punishment for some form of wrong-doing that has offended the supernatural forces that control life and death. This kind of symbolization is inevitable in large disasters, particularly in one of this kind. It was often expressed through Buddhist imagery.

The third encounter with death came not immediately after the experience, but years later with the experience of *later* radiation

effects, and particularly with the experience of what is called inaccurately in scientific terms, but with great emotional charge, "A-bomb disease." The medical condition that has become the model for "A-bomb disease" is leukemia. As most of you probably know, between 1948 and 1952 there was a definite increase in the incidence of leukemia. In those that were within 1,000 meters of the experience and survived, as few did, the incidence of leukemia increased from 50 to 100 times; this occurred to a lesser extent in those with lesser dosage of radiation. In any case, there was a definite increase in the incidence of leukemia. The symptomatology of leukemia, without going into this in detail, resembled that which I described for acute irradiation, sufficiently for survivors to equate them as simply a continuation on a psychological plane, of this encounter with death. It is not surprising that the Hiroshima or Japanese equivalent of the Anne Frank story is a young 12-year-old girl, Sedaco Sussaki, who died of leukemia in 1954. Subsequently, a monument was erected to her, and a children's organization formed in her name.

There are many other conditions which are controversial, including effects on the blood-forming organs or relationship to various anemias and so on, where there has been no absolute scientific proof but there has been some suspicion that these may be affected as well. As you can well imagine, there is also an enormous psychosomatic constellation around the concept of so-called A-bomb disease which can, I think, be related to the concentration-camp problem as well—a vicious circle surrounding the psychosomatic plane of existence because the survivor is likely to associate even the mildest everyday injury or sickness with possible radiation effects, and anything he relates to radiation effects becomes, in turn, associated with death. This is enhanced by vast dramatic reports of patients dying from so-called A-bomb disease (these reports are often inaccurate medically) at the so-called A-bomb Hospital (which is actually called the Atomic Bomb Hospital for atomic bomb survivors). The experience is publicized, sometimes in good faith by peace groups, etc., as a result of which psychosomatic anxiety is increased. There are varying problems of denial of illness, which is itself symbolic, so to speak, as well as psychosomatic. This evolves into a very elaborate chain of causation resistance, and patterns of what is sometimes referred to by Japanese physicians as "Hiroshima A-bomb neurosis," a condition whereby people simply become weak or often bedridden and focus

upon their blood count and their bodily symptoms. These extreme cases are relatively rare, but they do occur, and many people in Hiroshima, whether or not they have this "A-bomb neurosis," do have a nagging doubt about their own health and the possibility of being infected by A-bomb influences. Furthermore, there is the fear of contamination of subsequent generations and genetic effects. In this respect, happily, the results have been negative in comparative population studies. There has been no demonstrable evidence of any increase in genetic defects in the children of survivors, compared to the nonsurvivor or ordinary population. But, there has been one positive laboratory finding suggesting certain kinds of mutations in the sex-linked X chromosomes, in that among survivors who were significantly exposed, the male survivors have fewer female offspring than ordinarily, and female survivors have fewer male offspring, which is sufficient to make people worry that this laboratory finding might manifest itself clinically. There are indeed some Japanese pathologists who think there is evidence of a clinical increase in malformation, but this has not been proven.

In any case, on the psychological plane, we may say that this third level of encounter with death involved a transition in which the sudden course I spoke of before is an enduring taint of death which attaches itself not only to one's entire psychobiological organism, but to one's posterity as well. I would emphasize that most of these findings are subclinical; that is, these survivors work and marry and beget children in a more or less normal fashion. They have this undercurrent of imagery which they carry with them, and this imagery involves an endless chain of potentially lethal impairment which if it does not manifest itself in one year or in one generation may well make itself felt in the next.

The fourth and final of these four sequences of immersion in death or the encounter with death is what I called the identity of the dead. This is a life-long identification with death, dying, and with an anonymous group of the dead. It is, of course, a product of the sequence I have already described and has much to do with forming a highly ambivalent group identity in survivor populations. It is a very unwanted identity on the whole, as you can imagine, and the identity is symbolized externally by disfigurement—that is, by the keloid scars which are the stigmata of the atomic bomb exposure. Stressed here as a central conflict of "hibakusha" identity is the problem of what is

sometimes called "survivor guilt," or what I call "guilt over survival priority." To emphasize this aspect of it, there is the inner question of why one has survived while others have died, the inevitable self-condemnation in the face of others' deaths, for the survivor can never inwardly conclude that it was logical and right for him and not others to survive. Rather, he is bound by an unconscious perception of organic social balance which makes him feel his survival was made possible by others' deaths. If they had not died, he would have had to; and if he had not survived, someone else would have. This kind of guilt, related as it is to survival priority, may well be most fundamental to human existence. Of course, additional factors contribute greatly to guilt feelings which include—as has been mentioned in regard to the concentration-camp survivors—the survivor's joy that it was the other and not he who died, as well as previous death wishes which he may have harbored toward his parents or other family members. Much of this involves the pattern of the mourning experience, a subject which I hope to discuss later on. But what we see in the atomic bomb disaster is the failure in the resolution of many of these emotions. The survivors feel compelled virtually to merge with the dead and, in various ways, to behave as if they too were dead. They judge all behavior from the standpoint of the imagined criteria of the dead themselves. Anything which suggests strong self-assertion or vitality, which suggests life itself, can become a source of guilt in this identification with the dead. To put it another way, the identity in its significant symbolic sense becomes an identity of the dead taking the following inner psychological sequence: "I almost died. I should have died. I did die, or at least I'm not really alive. Or, if I am alive, it is impure of me to be so and anything I do which affirms life is also impure and an insult to the dead, who alone are pure." This, of course, is not a logical sequence, but it is a symbolic psychological sequence which I think the survivor carries with him, and it is an important one to keep in mind. It has to do with Japanese cultural emphasis upon the continuity between the survivors and the dead. This cultural emphasis does not create the pattern, it is simply one cultural manifestation of a universal potential, especially in such an enormous disaster or an extreme situation of any kind.

I want to stress, however, that one should not conclude that survivors are suicidal. On the contrary, I was, in fact, struck by the tenacity with which most "hibakusha" at all stages have held on to

life. Thus I have come to the conclusion that this identification with death, this whole constellation of inwardly experienced death symbolism is, paradoxically enough, the survivor's means of maintaining life, because in the face of the burden of guilt that he carries, particularly guilt over survival priority, his obeisance before the dead is his best means of justifying and maintaining his own existence. Of course, it remains an existence with a large shadow cast across it, and a life, which in a very powerful symbolic sense, the survivor does not feel to be his own.

Moving away from the experience itself, I want specifically to talk about some general aspects of the survivors—residual problems, especially those of psychological imagery that the survivor carries—and perhaps make some comparative comments on concentration-camp victims as well as the earlier work that I have done on those who have been through Chinese “thought-reform” or so-called brain-washing. That work, incidentally, is not primarily related to military personnel but rather to civilians, westerners, and Chinese intellectuals themselves. In any case, I want to emphasize the problem of death and death symbolism because I think the problem of the immersion in death and death symbolism is given particular vividness, almost exclusiveness, in the Hiroshima experience. Moreover, I think it is the psychological key to the understanding of the survivor.

In the Hiroshima experience as compared to the concentration-camp experience, there was a greater sudden immersion in a single overwhelming experience with death. There was also the unique feature of radiation aftereffects and death taint, which maintained direct death imagery over a lifetime—this is also affected by the overall nuclear weapons problem throughout the world. The Hiroshima situation, in contrast to that of the concentration camps, lacks the latter's total, chronic assault on the personality, over a long period of time. In both cases, I think the survivor is torn between two kinds of extreme imagery. One is a profound impairment in the sense of invulnerability, as a result of which the Hiroshima survivors had lost a certain fundamental faith in the structure of human existence. This, I think, is certainly true of concentration-camp survivors. There is also an unconscious fantasy of being the “elite” who have mastered death, as strange as it seems, among certain survivors, in which they become symbols for various rational and nonrational programs, including peace movements. Thus, the actual experience can become

a source of pride and strength, and that is one of the reasons why many survivors of both Hiroshima and the concentration camps will keep ruminating over their experiences. Undoubtedly, there are other factors (guilt, shame, etc.), but there is a certain involvement and a certain touching of dimensions of existence that one has never touched before or after, in the extreme experience that is expressed here.

There are, of course, long-standing patterns of grief and mourning. One can say that both the Hiroshima and concentration-camp survivors lived a life of grief. They mourned not only the dead family members, but the anonymous dead too, and I would stress the way in which people can be affected by anonymous deaths, as I found out in Hiroshima. They also mourned for their former selves, that is, to that which existed prior to this infringement of an overwhelming nature, this infringement by death imagery upon the self. That is why, because of this unresolved mourning, one might say the survivor is bound to the dead and bound to his grief.

The survivor experiences symbolic reactivations of this loss as well as outright death symbolism. This kind of reactivation may be strikingly observed in Hiroshima as a response to nuclear testing in any part of the world. It is also relived to a certain extent every August 6th when the Japanese commemorate the event, understandably, a highly ambivalent ceremony. I think the same principle applies for concentration-camp survivors, as for example during the Eichmann trial, or during any outbreak of anti-Semitism. The whole event and all its conflicts is relived by these symbolic reactivations.

I wish to say a word at this point concerning the concept of immersion in death as it relates to the end-of-the-world imagery. In a sense, the Hiroshima experience is distinguished by the living out in actuality of what is usually confined to psychotic fantasy—that is, an end-of-the-world experience. The end-of-the-world imagery, if it is to have its profound effect upon survivors, must attach itself to very early imagery from childhood, and it is this combination of the two that creates the overwhelming effect. It is my feeling that the early imagery to which this doomsday imagery attaches itself is the earliest fear of separation, particularly separation from the mother, perhaps originating with birth itself—the earliest kind of imagery of separation which is a kind of anlage of potential death imagery. This is expressed also in various avenues of hostility later on. When cer-

tain Hiroshima survivors have not been able to recover, they will have wishes of end-of-the-world fantasies toward the rest of the world: "I wish atomic bombs would be dropped all over the world and then they will be put through what I was put through." This is not usual, but it's kind of an undercurrent of thought among survivors which they are embarrassed to bring out or talk about. The totality of the disruption of reality creates really what I have come to think of as a psychic mutation in standards of reality, which makes an end-of-the-world experience of this kind a sort of imagery, the temporary norm that this experience imprints upon the psychic apparatus. This is very close to some things that Dr. Niederland has written about and spoke about earlier.

The ultimate threat, I would hold, in this death imagery is one that we overlook in many of our comments on survivor guilt and survivor problems. I think the ultimate threat to the survivor is that of his own death, that of the revived potential for death and death imagery within himself that he experiences constantly as a survivor, and also I would claim, an interruption of his own sense of immortality. I use that concept in a very broad sense, that is, a sense of something of his own creation, of his own influence surviving after his own biological death, whether this is biologically through the family, or theologically through notions of an afterlife achieved by creative works or even through nature itself.

Those, I think, are the four avenues of immortality. The survivor finds these threatened by his survival experience and by the imagery he has of the extreme situation involved with this immersion in death.

A second overall problem that proved crucial with the Hiroshima as well as the concentration-camp experiences and which is true of any extreme experience, as for example the Chinese "thought reform" program, is that of guilt and the relationship of guilt to death imagery and the survivor syndrome. I mention this perception of organic social balance in which the survivor feels that his life was made possible by other people's deaths. Even if family members haven't died, the survivor still has the same kind of experience. This was largely a symbolic experience for those exposed to the atomic bomb explosion. but in the concentration camp it was much more direct. The notorious selections that so many writers have described are really a literal expression of "You live, you die." The survivor of

such an experience is bound to have a direct kind of imagery that his life was made possible by others' deaths, in a much more concrete fashion than is true of the Hiroshima survivors who experience this guilt reaction in the more symbolic terms which I have described.

The specifically bizarre, horrendous, inhuman patterns of death itself, both in Hiroshima and the concentration camps, produced a markedly pronounced guilt syndrome. There is the concept in many cultures of the so-called homeless dead, a term referring to those who died with violence, or in unusual and horrible ways that are not consonant with cultural ideas about how death ought to occur. Those who perished in Hiroshima and in the concentration camps are in this sense homeless dead, and therefore the objects of greater guilt. Also, survivors feel guilty over their rejection of the dead, because inevitably they hold a great ambivalence toward the dead. They embrace them in the way that I mentioned in this identity of the dead, but at the same time they want to push them away, and many survivors were greatly relieved when the dead were rapidly removed from their environment through cremation. The fear of the dead is a universal one and is commonly expressed in the fear of ghosts, spirits, etc.

Often the question comes up, "What about expiation through suffering—don't the survivors gain certain psychological benefits, or at least don't they, in a sense, feel that their own earlier guilt is expiated through suffering?" Although this is true to some extent, that is, insofar as there is a kind of expression of masochistic needs, I have the feeling with Hiroshima survivors, and probably with the concentration-camp survivors as well, that the expiation is not achieved, that it is interfered with by the sense of evil that the survivor carries with him because he has imbibed the whole experience. If he is evil and is guilty in his psychic life, then he has contributed to the disaster itself in his inner symbolism. If he has contributed to the disaster itself, then he is responsible for all these deaths that have occurred, in a psychological way, and therefore he cannot necessarily achieve benefits of a psychological kind through expiation—or if he does, they are by no means enough to overcome the problems.

In Hiroshima, another aspect of guilt was its communal reinforcement. The fact that the whole city (and this is probably more unique of Hiroshima than the concentration camp) is immersed in the

experience creates a situation whereby people reinforce each other's guilt, creating a kind of guilty community of survivors.

The ultimate horror that I mentioned is common to both experiences, all too common in various ways. Another point about guilt is its sequential course as one moves out in concentric circles from the dead themselves. That is, the survivors feel guilty toward the dead; those who just missed going through the experience feel guilty toward the survivors; those who were even further away feel guilty toward this latter group; thus Japanese often feel guilty toward Hiroshima survivors and Americans feel guilty toward the Japanese. It should be kept in mind that guilt is frequently accompanied by hostility.

A third general pattern of imagery in survival is what I have referred to as "psychic closing off." This also relates to some of the psychosomatic patterns found in both groups, with which we are familiar. In Hiroshima, there was an overwhelming event that one had to defend against through this mechanism of "psychic closing off." This mechanism became a contributor, in turn, to the chronic sequelae of weakness and a variety of other psychosomatic complaints. With concentration-camp survivors, however, the closing-off process is much more chronic, in a sense more thoroughgoing because of the more pervasive nature of the chronic trauma. The long-term expression of the closing-off process is, of course, related to what I have described as the identity of the dead; if one doesn't feel one has the right to be alive, one is as if dead or a walking corpse, as Dr. Niederland put it in one of his articles. Then, of course, one remains closed off or constricted emotionally throughout one's life. It is a symbolic psychic death. Symptoms of fatigue, of restricted vitality, which are always present in most survivor syndromes, are also related to this. Some recent theories about psychosomatic illness regard it as a kind of entrapment where there is no other outlet for emotional relief—a formulation which relates to the closing off process I am describing. In order to overcome this psychic closing-off, various compensatory efforts are made, and that is why it seems that survivors of both groups are quick to marry and to have children. This is, in a way, an attempt to deny or master or emerge from the closing-off process. It also is an attempt, in my terminology, to reestablish a sense of immortality which has been interrupted.

The experience not only of death imagery and overwhelming

death, but also of being exposed to death in the midst of total helplessness before it, contributes to psychic closing off. That is, not only is death occurring around one but one can do nothing about it. Parenthetically, one of the explanations of the frequently raised question, not only by Hannah Arendt but by many writers, of why the Jews offered so little resistance to their exterminators concerns something akin to this pattern of psychic closing off whatever its origin. The lack of resistance is related to death imagery which, insofar as it is a typical response to an overwhelming death threat, was certainly present to a marked degree in the Jews who went to their deaths in a state of being psychically closed off. I would also stress here the experience of the investigator in these extreme experiences with regard to psychic closing off. I mentioned in my papers, and I want to mention now briefly, that I myself, in interviewing the first few of these Hiroshima survivors, felt slightly overwhelmed by what they told me. It was truly horrendous material, the things that I have quoted here, and I wondered a little way through whether I could really do this study. It seemed to be too much of a threat to me and too much of a psychological series of pressures, but very quickly I found myself getting over this problem and retreating behind my scientific function as an investigator, while trying to categorize the experiences that I heard. I could see, expressed in my own person, that this pattern of psychic closing off is necessary. One certainly cannot engage in medical work, surgery, be a fireman or a policeman, or anything similar without some pattern of psychic closing off. But this defense has its dangers; and the extreme dangers that we saw were well reflected in the concentration-camp experience especially in the extreme so-called *musulman*, who joined the ranks of the living dead and became a walking corpse who simply ceased feeling and gave up. In a psychic sense he was no longer really living; this was a psychic closing off of an extreme kind, which was no longer life-enhancing, but on the contrary, led directly to death. It is an example of how, as in so many forms of psychiatric symptomatology, what is in the beginning a form of adaptation, becomes, in the long run, a form of a disease. The same thing could be said, as Dr. Niederland and I were discussing, with regard to paranoid symptomatology during the concentration-camp experience. In a way, paranoid symptomatology is superior to—more reactive than—psychic closing off of the “*musulman*” variety. It was a relatively successful adaptation

compared to the “musulman,” but if it is maintained, it becomes a mode of life which is a severe illness in and of itself.

In regard to this psychic closing off, I would emphasize also the lifelong pattern of what Marcel, the existentialist philosopher, has called “under-living.” This relates to what was said about the incapacity to enjoy life or seek happiness, or what Leslie Farber, the Washington analyst, has called the life of suicide. It’s a kind of life of death imagery that can frequently evolve from this kind of severe experience. These patterns, incidentally, Marcel described in relationship to survival, but Farber described his in relation to other problems. So again, the problems of survival of extreme situations relate to general psychological issues.

There is one point I should like to emphasize at this time because I think it has been left out in discussions concerning rehabilitation and benefits for the survivors. What I found in Hiroshima survivors was the following combination: having been through this experience, having made this close identification with death and the whole gamut of imagery that I described, they felt themselves weak and in many ways inferior. They wanted and sought help from others while constantly lobbying for better benefits and increasing benefits, which indeed were eventually provided. On the other hand, they feel extremely ambivalent about receiving help, a pattern which expresses itself in what I call “counterfeit nurturing,” or a suspicion of counterfeit nurturing, that is, a suspicion of any kind of help which is perceived on the part of the person being helped as predicated upon his weakness and inferiority. So, it is a profoundly ambivalent pattern toward help—seeking it and resenting it—and this pattern of suspicion of counterfeit nurturing pervades the entire atomic bomb experience, as I suspect it does much of the concentration-camp survivor experience. It also could be thought of as victim consciousness, an aspect which Japanese intellectuals use not only about Hiroshima victims but about themselves—the Japanese people. This has other psychodynamic implications which I will not go into now.

There is a subjective sense of death taint which both the survivor and others feel in relationship to the survivor. Any of us who study this problem are struck by the enormous amount of hostility toward the survivor historically in almost all experiences—a hostility which I feel stems from this kind of death taint which others sense in the survivor, and which the latter feels himself to carry. Therefore, most

people will turn away because the survivor's taint threatens various mechanisms of denial of death as well as related issues about death symbolism, which are generally well defended. This, of course, relates to the notion of psychological contagion.

Studying some of the experiences of a plague in the 14th century was very illuminating. There was an expression by some observers at that time concerning the plague contagion that one man could infect the whole world. I think that relates to some of the psychic imagery about the survivors: that they can infect others by the fact of their survival—i.e., their survival is a living affirmation of death imagery.

There is also the actual problem of what might be called "survivor hubris"—this is a term used by Canetti (1962), to describe the need of the survivor for a constant experience of surviving. "Survivor hubris" is magnificently illustrated in the film "The Americanization of Emily," in which an American admiral, who has recently lost his wife, begins to crack up. He develops a hair-brained scheme for what he calls "the Tomb for the Unknown Sailor." In order to create this tomb for the unknown sailor, one had to obtain pictures of the first man dying on D-Day who was either a Navy man or a Marine, and a lot of people had to risk their lives in an attempt to get this picture. I would say, in terms of the imagery which I am describing psychodynamically, that insofar as he had lost his wife, he was, in a sense, a survivor and having the elements of guilt about this, his own sense of immortality had been impaired. Thus, he had to create a new one by this scheme of the tomb for the unknown sailor. (It must be kept in mind that he was a man committed to Navy tradition, etc.)

The survivor can be in actual danger in various symbolic ways that we may have to examine if he has a need for constant survival, that is, to constantly reassert his survival. He may, for example, be a leader of a nation, who in some way must create a situation where he is, in fantasy, the only survivor and requires the constant presence of a number of deaths around him in order that he remain the only survivor. This is a form of imagery that may not be directly applicable to the problems we are studying, but has indirect relevance for it.

More common is survivor exclusiveness: the feeling that no one else is capable of understanding the experience because of the shared encounter with death on this profound level. This creates a great deal of survivor antagonism which I found to be overwhelming in

the Hiroshima experience; these antagonisms relate, I think, to something Bettelheim has described: the way in which the concentration-camp victim (I would include the survivor too) later on seized all his cohorts as reminders of his own conflict and his own encounter with death, as well as his own potential deterioration.

There is also a pattern of "antagonistic cooperation," as some psychologists call it, between survivor and survivor, survivor and non-survivor, and even between survivor and perpetrator of the disaster. I think this could be explored in terms of the concentration camps during the experience, and subsequently with survivors in Germany; it might also be regarded in terms of the Americans and the Japanese in Hiroshima.

Finally, I wish to emphasize the problems of what I call "survivor's formulation" or "reformulation" of his experience. I think, in a way, this may be understood in terms of the resolution of the mourning experience. However, unless the survivor has some new formulation of what he has been through, some way of reestablishing his personal cosmology, his own inner ideology, he will have no way to deal with all of these overwhelming feelings that we know so well.

Freud (1917) in *Mourning and Melancholia* stressed that one of the problems of the depressive experience and of mourning per se was a creation and acceptance of a new reality. In a sense, the survivor has to form a new reality within which he can understand and master his experience. I found that in most cases religious principles were inadequate for the task, at least for the Hiroshima and concentration-camp survivors. On the one hand this failure may be related to the nature of religious imagery, its lack of power at this stage of human history, but on the other, we must consider the overwhelming nature of the disaster itself. Until one has achieved a formulation of this kind, hostility is likely to be great. With the achievement of this formulation, hostility diminishes. The end-of-the-world fantasy is one expression of hostility as applied to others. Somatic difficulties relate to hostility. Alexander Mitscherlich, the German psychoanalyst, had an interesting idea that relates indirectly to this problem. He felt that the impaired mourning of the Nazis themselves, the German people themselves, that is, the impaired mourning process toward the Nazi movement which the Germans loved (although they might have felt ambivalent about it), has subsequently interfered with German historical progress. One explanation for this is that

with the failure of resolution of mourning there is a need for denial and repression of guilt, as well as a resistance to those moves which would improve the situation and permit of progress. Impaired mourning has many profound psychological effects.

In the reformulation of the kind that I am describing, the survivor often has the need to fall back upon his earliest life imagery, a kind of golden age of the past. That is why he seems to stress the beauties of his childhood experience. I would stress this is not simply regression per se, but rather the calling forth of some of the early imagery of life, particularly that coming from the mother-child relationship—what I have called the emotional symbolic substrate which one must have in order to reformulate any experience in relation to a personal or historical change. This involves also the reestablishment of a sense of attachment, of a connection with people on the basis of various principles which I do not have the time to go into now. About the fundamental nature of the parent-child relationship, particularly the mother-child attachment, this attachment has been threatened in the survivor's experience and he has to reestablish it, often calling upon his emotions that come from the early mother-child relationship. He also has to reestablish a sense of meaning and significance in what he is doing; therefore, survivors of Hiroshima were quick to respond to the pattern of Japanese pacifism that swept the country after the war, as well as to various principles of making Hiroshima a city of peace, with artwork and imagery built around the concept of peace because this gave meaning to their experience. I think concentration-camp survivors in relation to Israel have the same kind of imagery, as do even parents whose children died of leukemia and then became interested in the scientific problem of leukemia per se. All this has to do with reformulating one's experience and in various ways reestablishing a sense of immortality.

DISCUSSION: SIMILARITIES AND DIFFERENCES BETWEEN SURVIVORS OF THE HIROSHIMA DISASTER AND NAZI PERSECUTION

DR. KRYSTAL:

I am sure that everyone here has been struck in many different instances with similar psychological aftereffects of massive traumati-

zation under widely divergent circumstances. Dr. Lifton has already pointed out a number of similarities in the psychological reactions demonstrated by the survivors of these two dissimilar encounters with death, as well as some similarities in the group reactions to an assault upon them. At this point, I want to pick up on a few themes which Dr. Lifton has presented in the hopes that a comparison may prove fruitful.

The most obvious theme is the image which the survivors have of themselves as having been rendered different from the rest of mankind. The survivors assume a special relationship to history—one in which they feel that they have been singled out with an ambivalent implication. As martyrs, they feel they are “special” and that no one can understand them; however, the attendant feelings of guilt and shame lend their feeling a defensive meaning. As Dr. K. R. Eissler has pointed out, one of the problems in dealing with the survivors is a feeling of contempt one tends to develop toward a humiliated, degraded creature. Our observations tend to confirm this, and furthermore suggest that such feelings take the form of self-contempt in the survivors themselves; in fact they have a need to provoke people to treat them contemptuously.¹ The event of the assault upon them becomes a point of fixation of their thoughts and interests, a focal point of their lives. The ambivalent feelings lead to a certain ill-hidden hierarchy among the survivors. In Hiroshima, this is thought of in terms of the distance to the hypocenter of explosion, physical injury, and loss of relatives. In survivors of Nazi persecution, there is a gradation between concentration-camp survivors and those who survived in ghettos, in forest retreats, on “illegal papers,” or in exile in the Soviet Union. The feelings of jealousy and resentment have made cohesion in the survivors of Nazi persecution a difficult task. The Nazis capitalized on such feelings by “evacuating” Jews and concentrating them in ghettos and concentration camps. They exploited the reactions of the host population which were similar to sibling rivalry. They also exploited the horror of the German Jews upon confrontation with the already degraded, ghettoized Polish Jews. Playing upon the identification with Germany of the newcomers, they cultivated informers and spies in the ghettos. On the other hand, in the concentration camps, there was an exploitation of the identification

¹ Communicated at the APA convention, May, 1966.

of the "old prisoners" with the aggressor. In this way, the prisoners with the capacity to identify with the sadistic behavior of the S.S. men were made Capos and Lagerälteste. In the same way, Jews from Southeast Europe, while in the concentration camp, identified Central European Jews as their enemies, a feeling which carried over into the postliberation years. Thus, a conscious manipulation and exploitation of destructive forces within an abused and beleaguered social group was capable of also producing social pathology after the liberation. This we observe in the fear and distrust of all men, which the survivors have, as well as specific frictions between the groups. For instance, in Detroit, Jewish immigrants of the "survivor group" do not mix but are divided according to their country of origin, e.g., Polish or Hungarian Jew. Where a "mixed" marriage between members of these two groups takes place, social symptomatology can be found in the marriage and in the larger family.

Also highly characteristic are the aftereffects of a massive encounter with death. The problems of identification with death in the concentration-camp survivors are quite conspicuous. Many have not been able to enjoy life at all, but see themselves only as a living monument to the "martyred six million." This feeling is so widespread and important that it makes comparison with other groups very difficult. I have pointed this out (Krystal, 1965) in connection with Eitinger's (1964) attempt to compare Norwegian and Israeli concentration-camp survivors. The incarceration of the Norwegians was punitive, had some causality, and the prisoners had an identification with a political movement. The Jewish survivors had none of these and, in addition, were confronted with an irresistible, impersonal destructive machine which consumed their families, homes, communities—their "whole world," and their incarceration was not for punishment but for destruction through labor (Hillberg, 1962). Thus, in regard to identification with death, world-destruction imagery, the Jewish survivors share the feelings and ideas of the survivors of atomic bombing.

Two other phenomena took place in the Hiroshima survivors and the concentration-camp survivors which have produced specific after-effects: (1) the feeling of paralysis upon the encounter with an overwhelming, irresistible destructive force. This type of an event tends to produce a specific disturbance of cognition and memory which has been described in detail in this volume (Chapter 3); in addition,

it tends to set up an "irrational," and possibly unmodifiable fear of the return of the overwhelming threat; (2) the phenomenon of "psychic closure" described by Dr. Lifton so aptly. We have tended to call it automatization or robotization of the concentration-camp prisoners. The idea, however, is the same. It represents a freezing of affect, which has persisted for years after liberation. French workers have called this phenomenon "affective anesthesia," but it is more complex than this label implies. It includes a number of reactions such as the inability as well as the fear to mourn (Meerloo, 1964, this volume) and the threat of the return of aggression.

Finally, the fixation on the memories of the "ultimate horror"—the nuclear destruction of one's own family—with special circumstances as having to bury or carry to the crematorium one's own family, or having to work in disposing of their clothes and possessions, e.g., packing them and sending them to Germany—all this seems to be so disturbing a thought as to set up a traumatic screen upon which all of the later life's experiences are projected.

There is again a similarity between the Hiroshima survivors who could not give their dying relatives any water because of its contamination, and the concentration-camp survivors who were forcibly prevented by the S.S. guards from giving any comfort to those condemned to die. S. Kossak (1946) has described how in Auschwitz it was a capital crime for a Jew to give water to the people in Barrack 18, who were selected for the gas chamber and had to wait there nude for 12 to 24 hours without food or water.

As a result of such experiences, the attitudes toward the world are permanently modified. There is a fear of bringing another generation into being. In Japan, this fear was rationalized by the danger of genetic changes. The survivors of Nazi persecution, after consciously rejecting the idea of having children, had an extremely high rate of miscarriages and a low birth rate. The median in the survivor families falls considerably below two children per family. The only reason that the survivors had any children at all was a need (working in the opposite direction) to try to undo the destruction magically by creating a family as soon as possible—often under the most unfavorable conditions of the D.P. camps.

Dr. Lifton has pointed out the process of denial of illness in the "hibakusha." As has been pointed out repeatedly in our conferences, the survivors of Nazi persecution have been involved in a massive

denial of their emotional and physical problems, which broke down only partially in some individuals 20-25 years after their liberation. This denial had even preceded the actual execution of the extermination, as pointed out by Hillberg (1962), and has continued while the assault went on (Bettelheim, 1960). Perhaps such a massive destruction is incomprehensible, just as is one's own death.

Because of the disruption of the survivors' trust in the world, the very deepest level of confidence seems to have been reached, and in some destroyed. I am referring to the basic trust and faith which develops from the earliest mother-child relationship. The destruction of this confidence makes the survivors react to attempts at helping them with the suspicion of what Dr. Lifton called "counterfeit nurturing." We have ample confirmation of such reaction to agencies and families who tried to reconstitute the lives of the survivors. Dr. E. Sterba has described this especially amply in Chapter 4, in relationship to adolescent survivors. However, in addition to being unable to receive nurturing, the survivors have often shown evidence of being unable to give it. Hence the frequent problem among survivor mothers in finding themselves bewildered about their role as mothers. They seemed to have lost the introjected prototype of the good mother to a significant extent, or lost access to that part of their object-representations. As a result, we now see increasing numbers of children of survivors suffering from problems of depression and inhibition of their own function. The survivor mothers tended to need a symbiotic relationship with their children, and the dread of their own aggression interfered with their children's accomplishment of successful individuation and separation. Hence we see pathological symbiotic relationships between mothers and their children (sons especially) which negate the latter's ability to establish themselves as successful parents. This is a clear example of social pathology being transmitted to the next generation, yet there are no provisions in the German restitution laws for the rehabilitation and treatment of the children of survivors.

The denial of this problem is common to the survivors and the present German authorities. It represents an example of a complex interreaction between victims and perpetrators. In various forms and combinations, these types of relationships have continued in the postwar period. In Hiroshima, there is an effort to pacify the world, including the American victors. Among the survivors of Nazi perse-

cution, there is an especially ambivalent attachment to the former German aggressor, manifest in myriads of public and private constellations. Even in the United States, some survivors have the need to seek out German employers or other associates and continue to keep this ambivalent attachment alive.

DR. SZATMARI:

I might sit here for 10 hours and discuss Dr. Lifton's paper, but at this time I am concerned about one particular aspect of the concentration-camp problem: namely, the missing grave. Burial as a ritual has great significance throughout human history. I hear many times from patients, "If I only could go to the grave of my son, my mother, my father!" I wrote to the Pentagon asking them about how they deal with the mothers and fathers of the American soldiers who died. They said that a trip to the grave sites has been provided for family members because this is the only way that they can relinquish mourning. The concentration-camp victims have no graves by which to be remembered; there is not even a grave of the unknown soldier. Would that have any significance here?

DR. KRYSTAL:

I think that it is an interesting point in this regard: there have been a couple of attempts to erect monuments in Washington recently, which have been disapproved with the idea that if a monument of this kind is erected, anybody and everybody will want to build monuments. Also, in Detroit, the survivor groups have decided to build a Recreation Center in memory of those who have been killed. There are going to be facilities for a synagogue, gymnastics, swimming, and cultural activities. I think that this is in keeping with the Peace City of Hiroshima. The striking thing about these plans is the interest in monuments, but *not* in rehabilitation centers for survivors.

DR. GROBIN:

Much has been made, in German literature, and also in ours, of the fact that there was a distinct difference between the civilian population in Germany, particularly the German prisoners-of-war

who returned from Russia, and the concentration-camp survivors. The experience with the prisoners-of-war was used as an argument against our claim of late damage; it was stated by various writers that after two, three, or four years most or all the symptoms disappeared. Now, Professor Venzlaff is here and it would be very interesting if he could enlighten us to whether that opinion still exists. I personally do not think that these are well people. The same situation applies in the Canadian survivors of Hong Kong, the "death march" of Bataan survivors, and others. These people are permanently scarred, and this should be brought home to the German doctors who are reviewing our papers, as well as to all doctors who are dealing with such people.

DR. KRYSTAL:

I think that I can speak for Dr. Venzlaff because he did articulate this last night to the Michigan Society for Psychiatry and Neurology. He finds very similar findings, especially in the youthful groups who were among the people imprisoned in Soviet Russia or in other places for a long time—very similar psychological and psychosomatic findings. The view that all the veterans became well after a year or two is also familiar to us in our own Veterans Administration, and is so much wishful thinking. This subject has been carefully studied and documented by Norman O. Brill (1955), H. C. Archibald, Gilbert W. Beebe and others (1962).

In regard to the German prisoners-of-war, there is a tendency to equate their experience with the concentration-camp survivors. As a generalization this is false. Being a prisoner-of-war has a different perspective; it doesn't quite have this identification with the dead, survivor guilt, etc.; but when we realize that the emotional after-effects are produced by the psychic reality of the people involved, we can anticipate aftereffect syndromes.

DR. TANAY:

The inability to mourn, for whatever reason, is pathogenic now, but it was adaptive then. Frequently, I ask the survivors, "What do you think helped you to survive?" I don't put it in the form of "Why did you survive?" which is the frequent question they have been asked immediately upon liberation. The frequent answer is, "I lost

all feeling.” The fact that they were able to function depended upon the closing off that you have just described. The effect of the inability to mourn, I think, is very pathogenic. I have been teaching a class of industrial physicians and for the last few sessions we have been dealing with amputees. They presented a number of cases to me and it so happened that we got involved in a series of reactions due to amputations. We reached the conclusion that the difficulties experienced by the amputees develop later on; at first, they make a fairly good adjustment. The amputation is carried out, after which the amputee is returned to the plant—usually the same job. General Motors Corporation and all auto makers have the same policy: the worker must go back to the same department. Six months, or a year later, these people develop great difficulties. We have reached the conclusion that it has to do with the fact that they were not allowed to mourn for the loss. As soon as the surgery is completed, the approach is “return to the front line.” You know this was the slogan of American psychiatry during the war. However, it is perpetuated even in industry. In a few of these individuals whom I have interviewed, it was obvious that had they been permitted to mourn in the early stages and adjust on a lower level, many difficulties would have been avoided. This is only one aspect of it—there are numerous other facets.

DR. KRYSTAL:

That brings up another problem for the doctor in the management of convalescents. The point is that the doctor has to participate in the mourning in order for the patient to mourn, and since he often has to ward off such feelings in himself, he cheers up the patient or he doesn’t make himself available to the patient, because if he is available to the patient, the patient starts looking worse and is more depressed and it seems that he is getting worse.

DR. TANAY:

This problem is related to the denial of the trauma. Denial is the major issue that we are dealing with all the time. There is a “conspiracy” of silence about trauma which begins with the patient and includes doctors, lawyers, and even historians. We are angry with the Germans because they claim lack of knowledge about the activ-

ities of exterminations. I submit that part of this is a projection of our own guilt at avoiding facing up to the painful past.

DR. GRONNER:

I made myself a little list, not only of parallels but of contrasts between the two experiences because I think it is necessary to keep these in mind. For instance, the survivor priority was quite different because, as Dr. Lifton stated, in the concentration camp it was actual selection; however (I have run into this quite frequently), certain survivors really owe their survival to their own capacity for adaptation and real cunning. I have found when I inquired about the circumstances of certain crucial moves on their part, and through taking a very exact history of these days and their maneuvers (hiding under the bed, pushing somebody else into the line, etc.), the more they had an active, aggressive part in their own survival, the more they deny it because of guilt, and simply feel that it was just luck, senseless luck. The more they were beneficiaries of accident, the more they would assume a responsibility for their survival.

This brings me to another element: the business of the senselessness of the whole experience. I think that here there is a real difference between the prisoners-of-war, soldiers, and even the bombed population. For soldiers and prisoners-of-war, a cause, no matter how illusory, has always been available. The event in Hiroshima was a cataclysm because the people had no precedent by which to prepare themselves to master the experience; they didn't know what was happening to them. What happened to the concentration-camp victim was unimaginable, unprecedented, and utterly senseless. I have frequently seen survivors just sit in my office and cry—they are very puzzled—it doesn't make any sense to them—they can't make any sense out of their experience.

Another aspect is the end of a mode of life as it has been known. I think this affects the German-Jewish victim much more than the Polish or Russian Jew, who has always known a life of isolation and persecution. His imprisonment in a ghetto, for instance, was only different in manner of terror and starvation, but not much different, in terms of actual life style, from living in a small isolated community. The German Jew, who was suddenly thrown out of an assimilated life, received a much greater trauma in terms of identity.

Now, a word about impaired mourning. Psychodynamically, we know that impaired mourning leads very easily to paranoia, and I think that many of these paranoid symptoms are simply a result of this impairment.

One last comment about the examiner's experience. My own involvement in this kind of work proved exceedingly difficult. Originally when I was approached with a request to work with these people I said, "I can do very little because I haven't got the time." Within a very short time I discovered that it was not a problem of time, a revelation which was rather shattering for the first few months. One case per week was about the maximum I could stand. It was only after my own working through succeeded and I could gain some perspective of it, that I was able to do more. However, this is important too, though it is not an alibi, for the sometimes hostile and intractable attitude of many German psychiatrists (and even some in this country), because the closing off happens so rapidly that there is an absolute wall—it is the only way these people can really see these patients.

As to the missing-grave situation—actually, there could be plaques because, after all, the names are known and so is the probable location. I think many people would make pilgrimages, although not to Washington.

DR. KRYSTAL:

But you know, the plaque is not a grave. The idea of the grave is that the remains have to be there. Thus in addition to the problem of the missing grave, we also have the problem of the missing corpse. Our psychoanalytic work has pointed up negative ramifications of this lack, especially in relation to dread of the return of the feared "ghost."

DR. WANGH:

As a psychoanalyst, I do want to mention a dimension that I think is significant for whatever therapeutic purposes we have in mind for any of these survivors. If what I speak of as an added dimension seems frivolous, this will be an indication of your resistance to the very dimension itself.

Dr. Lifton spoke of the symbolism of death itself; namely, the

symbolism of castration. This leads us to the sexual reservoir which man uses to help him digest painful experiences. These painful experiences become incorporated into his sexual life and thinking. Sexual life absorbs into itself patterns which relate to anxiety and guilt-arousing experiences of not directly sexually (genitally) derived origin. Therefore, in order to obtain discharge of mourning, for instance, one would have to cross this sexual barrier—a barrier which may be one of masochistic-sexual character. Such sexual fixations stand in the way because people wish to hold onto mechanisms which had, at one time, been lifesaving inasmuch as they offered some degree of gratification and made life worth maintaining. I mention this only because in general, and in psychoanalysis too, we are often inclined to forget the castration complex. We talk rather about symbiotic experiences, mother-child nursing experience, etc. Repression may be at work upward or downward in the direction of libidinous evolution. Thus, “death symbolism” may also carry, beneath its own meaning, that of castration.

DR. KRYSTAL:

Dr. Niederland had previously pointed out the same aspect of death symbolism as activating castration anxiety. In our most recent joint study, we found that the women who were raped were among the sickest. When one considers the event from the purely biological point of view, it would not be quite so easy to explain because besides rape these women were subjected to many other traumata. However, when the sexual aspect of the masochism becomes conspicuous, the disturbances in this particular, very superficial study have also become significantly correlated.

DR. KERENYI:

Dr. Lifton's excellent paper represents a most interesting and relevant parallel to the studies made on the concentration-camp survivors' psychopathology. With such and similar papers from other related fields, for instance those on prisoners-of-war, a more generalized picture gradually emerges of a human condition, that of massive traumatization under the most varied circumstances.

The tremendous amount of pertinent observation and information contained in Dr. Lifton's paper opens up new vistas in our

understanding of the concentration-camp survivors' psychological problems.

I would like to mention briefly a peculiarity of some concentration-camp survivors, especially those with major disturbances of reality testing: namely, their fear and distrust of authority and their ambivalence or negative feelings towards doctors. It happened on several occasions that such patients developed delusions of persecution against me, although I made the most consistent effort to help them while feeling and showing a great deal of empathy. Despite the fact that I interviewed them in Yiddish, whenever they detected a German accent on my part, they became suspicious and accused me of being a Nazi in disguise; one female patient actually struck me. This type of transference became a very difficult resistance to handle.

DR. KRYSTAL:

It has been one of the most consistent motivations for our workshop to be able to arrive at a generalization in our work which will provide useful information about the diagnosis and rehabilitation of massively traumatized individuals of diverse backgrounds. I would like to give Dr. Lifton a chance to answer the many questions and comments posed here.

DR. LIFTON:

There is little to answer because for the most part, people seem to have reaffirmed most of the issues that have arisen rather than contradicted them. I will be very brief, partially to make up for my garrulousness of before. But one or two issues are very important and I want to at least comment on them.

The issue raised by Dr. Szatmari about the missing grave is relevant. In Hiroshima it proved impossible to locate the remains of most people who were annihilated by the bomb. This was especially tragic because many of the victims were children who were on work details. They were not going to school; they had been assigned to work in factories or to do work of one kind or another. They were right in the center of the city; no trace of them was ever found. Subsequently, there was an enormous and very specific guilt reaction on the part of the parents for having allowed their children to be there.

It is true that the Japanese custom doesn't place as great a stress on burial per se—they do cremate on the whole—and they were able to and did cremate rapidly whatever remains they had, both for health reasons and in keeping with tradition. Nonetheless, because the survivors didn't know which remains belonged to their family members, the problem of unresolved mourning became more highly accentuated.

What I think happens then is that any people, after a disaster like this, try to create a possibility of mourning. Thus in Japan and Hiroshima they did build monuments, especially the large Cenotaph which is the main monument on which all the names of the known dead are listed, even though this comes to around 60 to 70 thousand. They are actually all listed on this monument. However, it is my feeling that such token expression is never really experienced as authentic on a really deep psychological level by the survivors, so the mourning is not entirely accomplished. I feel that this conveys why I find the Hiroshima people so ambivalent about the monument itself or about any city ceremonies. They just don't feel right. The only thing that comes close to authenticity is a very personal, direct expression of grief.

SUMMARY OF THE DISCUSSION OF DR. LIFTON'S PAPER

E. A. SCHILLINGER, D.O.:

We concentrated our discussion on death symbolism, having started off with a notion of immortality. It was suggested that the methods used to obtain immortality have traditionally been through the culture of marriage, children, and creative works. In postwar Japan, as a result of the A-bomb experience, a new method seems to be taking shape insofar as an attempt to create immortality is concerned—this is the survival by nature. An expression that was used frequently in Japan was: "The state may collapse, but the mountains and rivers remain." Thus there is a tendency to again preserve "nature," to save the primitive forest, which perhaps corresponds to the tendency we have to preserve the timeless elements in our land.

We considered the problem and nature of death symbolism in the nuclear age. The fact that the nuclear weapon creates such a holocaust, a disaster which exceeds the usual but perhaps not schizophrenic ideas of world destruction, destroys the usual methods of denying death as well as the myths of immortality. The destructive power of the bomb is so great that one can reasonably expect only certain forms of nature to survive.

In the survivor syndrome in Japan, as opposed to the European situation, guilt tended to be minimal in the early phases. During the later phases, however, guilt became a prominent symptom; everyone adopted the attitude that life was very fragile and that vitality was wrong. It was then that the element of despair set in.

Children represented a special problem, in the sense that when they lost both parents the ambivalent attitudes became overwhelming for them. Parents who lost all their children developed the feeling that the "order of the death" was wrong. Certain of the survivors in Hiroshima deliberately emphasized their homelessness as a result of the bomb. There was a question as to whether this was not an expression of survivor guilt. Some survivors, having moved to a different part of the country, disguised the fact of their former presence at the explosion site. Some of the men interviewed actually tried to give the impression that they were the sole survivors of their families, denying the existence of relatives who had moved away.

The notion of *counterfeit nurturance* was discussed, i.e., the tendency on the part of survivors, in the later stages, to feel helpless but to refuse help, to be suspicious of nurturance because of the idea that it wasn't sincere. In those situations where the individuals weren't killed right off but had a lingering death, the families involved, after the initial profound shock, developed the notion that this illness was not only terrible but that it was actually somewhat indecent. An ambivalent situation developed in which they identified with the patient and yet had such horror of the circumstances that they rejected him, with subsequent tremendous guilt.

The major problem here was the notion that this was a completely inappropriate death, and the word "appropriate" was discussed as being the important one here. However, interestingly, we see similar reactions in concentration-camp survivors, in whom the mysterious radiation disease was not present. We are dealing with a problem of identification with death and with the dead, which contains am-

bivalent feelings toward the dead and toward one's self. The idea of shame seems to be, in part, related to the survivor guilt, as well as to the regression involved in the survival.

There seem to be some universals in the death symbolism residual from a disaster, a special imprint upon the survivors. However, this effect is extremely complex, as it is contaminated with problems of survivor guilt, shame, and ambivalent feelings directed at the killed relatives. Extremely common are reactions of unresolved pathological mourning, producing masochistic and depressive tendencies.

VIII. Psychotherapy with Survivors of Nazi Persecution

PSYCHOTHERAPY WITH CONCENTRATION-CAMP SURVIVORS

KLAUS D. HOPPE, M.D.:

Twenty-three years after their liberation from German concentration camps, George Sand's lines still apply to the former victims: ". . . Humanity is outraged in me and with me. We must not dissimulate or try to forget this indignation, which is one of the most passionate forms of love." Whereas numerous publications have appeared concerning the clinical picture and the estimate of damages regarding restitution, little attention was devoted to psychotherapy as a means of indemnification. Although officially the Federal Republic of Germany does grant funds in certain cases for prolonged psychotherapy, the procedure and red tape connected with it are at times insurmountable. The situation is rendered even graver by the fact that in cases where psychotherapy has been successful, the victims' pensions were reduced. This may cause survivors as well as psychiatrists to refrain from applying for funds for psychotherapy in the future.

During the years 1962-65, 17 former concentration-camp inmates received psychotherapy in our clinic. In order to illuminate the specific problems and the difference in the degree of disturbances, as well as the connection between the persecution, life history, and personality structure, we shall present two case histories.

Apart from psychodynamics, especially genetic considerations, the

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influence of the psychotherapeutic situation, the reactions of the therapist, and the resulting variables will be discussed.

Case 1

Mr. Samuel B. has been receiving compensation from the German Government since 1958 following a neuropsychiatric examination in Israel in 1956 when brain damage due to persecution was diagnosed. This ailment decreased his earning power by 40 per cent. Mr. B. had since been seen by several physicians and specialists, none of whom could substantiate an organic damage.

In August, 1963, Mr. B. started his psychotherapy. For six months he had been unable to follow his occupation as a carpenter due to severe headache and cardiac pain. He could not sleep despite medication, felt worried and dejected during the day, and would ruminate about this distressed condition and whether or not he should commit suicide.

Mr. Samuel B. was born in 1922 in a small Polish town. After completing the local grade school, he started helping his father in the manufacture of horse-whips. In 1939, following the German invasion, he was forced to work for them and was frequently beaten up by German guards. From 1942 until his liberation in 1945, he was in German concentration camps. There he became emaciated to the point of appearing a mere skeleton; nevertheless he worked hard, thus avoiding extreme punishment. A few months after his liberation he married a girl from his home region. He lived with her in Western Germany until his emigration to Israel, where he worked as a carpenter. When his relatives in the United States told him of better living conditions there, he moved to Los Angeles in 1958.

His psychotherapy consisted of 51 hours—from August, 1963 until June, 1964—with the patient sitting in a chair. He was re-examined in September, 1964 and May, 1965.

Material and Psychodynamics

During the first hour, the patient talked about a short dream he had the night before. He saw his father who had been gassed in a German concentration camp in 1942. In the dream, he did not feel anything about his father, although his father and his mother had allegedly always been very fond and considerate of him. When he was a child, his father took him along to the synagogue and saw to it that the boy received a strictly orthodox education.

Until the age of 12 he shared a bed with his father, while his mother slept with his sister, seven years his junior. Only if he got sick would

the mother take him into her bed. As a child he suffered from frequent colds and was prone to other illnesses.

It was also during the first session that the patient recollects the following: When he was a child he would wait every evening until his parents asked him to go to bed. As long as they did not ask him to do so, he felt an increasing tension and nourished the thought that they ought to ask his pardon. Finally he could no longer stand the inner tension and would initiate some kind of conversation, whereupon his parents would send him to bed. This seemed to him like an excuse from them and he would then go to bed and sleep without difficulties.

During the fifth session, Samuel B. remembers that, at the age of 13, he had asked his father why he was not working as fast as he himself. This remark made him feel guilty for many years thereafter. Two sessions later the patient admits that his father had been very strict with him and had not acquainted him with the entire process of his manufacture. When he was 16, he ruminated how, with his limited knowledge, he would ever be able to have a family of his own. He felt strong doubts about himself, but never discussed these feelings with anyone.

During the tenth session, in October, 1963, the patient talks in detail about his dependency on and submissiveness to his father. He admits that at the age of nine he had wished his father would die. This desire seemed so horrible to him that he felt perpetually guilty and tried to make up for it by overdoing his duties. He had been most fearful lest his father find out these thoughts, and had subsequently accused himself constantly, ruminating about these feelings time and again. Later, in the concentration camp, he considered the forced labor an almost just expiation.

The recollections on the part of the patient and his associations concerning his relationship toward his father disclose his fixation upon a negative Oedipus or apprentice complex (Fenichel, 1945). This complex was revived in the concentration camp and, to a lesser degree, in his later relationship toward his foreman in Israel.

On the other hand, the patient's recollections concerning his mother remain on the surface. The deep repression and denial of his oedipal and oral feelings toward her could not be revealed. This lack is doubtlessly related to the patient's ambivalent relationship to his wife, whom he considered very resolute and domineering. Since the wedding he had nurtured daydreams about nude girls and felt guilty toward his wife. The marital relations consisted exclusively of a coitus interruptus except for the periods of his wife's two pregnancies. In Israel a psychiatrist had pointed out to him connections between his psychosomatic disturbances and the coitus interruptus. Thereupon, the patient did not

consult him any more. Samuel B. adds that he originally felt cardiac pain in 1946 when, prior to his marriage, a female cousin whom he liked very much did not pay any attention to him.

In conclusion, we might say that the patient's obsessive-compulsive traits are linked to a resomatization of affects (Schur, 1955). There is particular use of deneutralized aggression to support the psychosomatic symptoms. The predominant fixation upon the anal phase, the submission under a sadistic superego, and the formation of a masochistic ego are expressed in constant self-accusations, self-punishment, and tormenting ruminations. The suppression of sexual gratification through interrupted marital relations and the shifting and regression to erotic fantasies according to the primary process thinking increases the tendencies toward self-punishment, and thereby the psychosomatic symptoms.

With regard to the cardiac pains or heart neurosis, Freud's (1895) original concept concerning the significance of a coitus interruptus is confirmed. The patient revives primary anxiety, oral guilt (Bacon, 1954), and dependency. Only after overcoming his clinging modes and his separation anxiety (Fuerstenau et al., 1964/65) did he lose his heart neurosis.

The Therapist's Reactions

We are mindful of the fact that the patient came from an orthodox family of lower-middle-class in Eastern Europe. During the first sessions the patient's expectations are fulfilled insofar as the attitude of an omniscient doctor is assumed, and he is not confronted with his submissiveness. Because of the revealing recollections and associations concerning his childhood, especially the relationship to his father, the patient is soon questioned about his feelings toward Germans and the therapist in particular.

During the twelfth session, after some denial and evasions, he voices his first criticism concerning the therapist. He doubts the value and success of such treatment, stressing his continued bodily pains and suicidal ideas. These objections of the patient are accepted and used for further working through of connections between emotional and bodily pain. Later on simple explanations are given about the connection between his somatic pains and emotional conflicts. The patient asks for such explanations several times, emphasizes his willingness to grasp them, but uses them at first for rationalization and a renewal of doubts.

Following a phase of increased resistance in December, 1963,

Mr. B. rebels openly against the therapist by signing a certificate for the restitution office denouncing the therapist. Self-punishment and submission under the former authorities are connected with punishment of the therapist. Following the rebellion, the patient's condition deteriorates and he complains especially of headache. The working through of the underlying psychodynamics leads to a more independent and relaxed attitude. His relationship toward the therapist as well as his condition show an overall improvement.

The Therapeutic Situation

Early in the treatment, Mr. Samuel B. is confronted with his defense mechanisms and resistance. Treatment motivation (Hacker, 1962) is conducted with him to a large extent and explanations as well as information are given regarding the goals of psychotherapy and relations between body and emotions. The acceptance of all his feelings and statements strengthens the patient's self-esteem and challenges him to voice his own emotions and objections. Soon a new base for cooperation is reached. With a significant decrease in the patient's submissiveness the therapist reacts with gradual decrease of the demanded authoritarian attitude. Thus a working alliance (Green-son, 1949) is established.

At first, the patient's resistance revolves around psychosomatic symptoms. Later on the coitus interruptus appears. While self-punishment, repression, secondary gain, acting out, and erotization (Menninger, 1958) on an oral-anal level markedly lose strength and can hardly be observed anymore by spring, 1964, the patient remains fixed upon his repetition compulsion. Throughout the treatment he practices coitus interruptus with the simultaneous use of contraceptives.

It is remarkable how little the concentration-camp experiences seemed to have influenced the patient's personality structure and his psychodynamics. Basically, he felt that pressure and threat exerted by the S.S. were only a continuation of the overpowering paternal authority. Therefore, he submitted to them in exactly the same childlike manner (Cohen, 1953). The incomparably more gruesome pressure by the state authorities in the concentration camps silenced the patient's guilt feelings toward his father image. At that price, he would take any kind of slave labor upon himself. Keeping this in mind, we are able to understand his remark that his work in Israel

had been worse than that in the concentration camps. It was during that time in Israel that the first prolonged psychosomatic disorder appeared. The patient's existence in the concentration camp is therefore regarded and treated as the joint between the traumatic inner experience of his childhood and youth and the later manifestation of these disturbances.¹

Resulting Modes of Behavior and Structures

At first the patient's transference is mainly influenced by his father image and his overpowering conscience. Later on the patient is somewhat pretentiously demanding that the therapist should spoil and support him like a giving mother. When he notices the therapist's increasing abstinence, his feelings of rejection and frustration are discharged in the above-mentioned rebellion. Now the control of countertransference is especially important and difficult, because the patient has endangered a continuation of the treatment by signing the certificate. The situation can only be mastered with the help of his active and understanding wife. For a short period, Mr. Samuel B. relapses into his former attitude of dependency on his wife and therapist. His facial features are again distorted by anxiety and pain. He complains about the hopelessness of his life and the badness of his thoughts.

He is reminded of previous fluctuations in his behavior and condition. In the twelfth session, a change in the patient's attitude toward his job is noticed after he voiced his first criticism. He quits his job as a carpenter and instead helps his wife run a home for the aged. In October, 1963, for the first time the patient is free of pain. He takes the required examination and becomes an American citizen. In November, 1963, however, he again complains of increased cardiac pains and is afraid of dying. In December these complaints decrease in direct proportion to the increase of his resistance. In

¹ The following experience was reported in 1945 by von Uexkuell (1963), a well-known German authority on psychosomatic medicine: The author had diagnosed a heart neurosis in a recently liberated concentration-camp survivor. After assurances from the doctor, the patient stated: "You know, doctor, when I lived in Poland I suffered from the same heart pains I have now. I saw many physicians and several medications had been prescribed. But it was of no avail. Then they told me to take it easy, which only made things worse. In the concentration camp the pain suddenly disappeared. Whether you believe it or not, in the camp I was the healthiest person you could imagine." When the patient was about to leave, he turned back saying: "Believe it or not, doctor, this imagined fear is far worse than real danger."

January, 1964, following his rebellion and the short relapse, these earlier fluctuations are used for further working through, especially in regard to his guilt feelings toward his wife. Mr. B.'s condition improves considerably in January and February of 1964. He seems relaxed, is able to sleep through the night without pills, and enjoys his job in the home for the aged. In March even the remaining somatic complaints disappear.

During the same period Mr. B. consolidates his status within the family. While he has previously been more or less only a plaything in the hands of his wife and the children, he is now conscious of his role as husband and father and rejects excessive demands and expectations. Instead of his former dependency, he now enjoys rights with his wife in their common task.

Finally, Mr. Samuel B.'s attitude toward the past changes. In the synagogue he is able to weep about the fate of his murdered parents and relatives. The interpretation is given to him that now he is strong enough to feel sorrow about their loss, and that his rigid dehumanization of the father as an authority figure has been dissolved.

During the re-examination in September, 1964 and May, 1965, the patient states that he is free of complaints, no longer nourishes any sexual fantasies or ideas, and is enjoying life with his family. During marital relations he will, however, frequently fall back upon the coitus interruptus. He adds with a smile, that after all the therapist need not be right in everything.

Case 2

In October, 1964, Mrs. Esther C., born in Warsaw in 1906, started psychotherapy and was seen for two hours weekly. The cost had been assumed by the German Indemnification Office in recognition of her "severe depression with paranoid ideas due to persecution," causing a total loss of earning power.

Material and Psychodynamics

In the beginning of her treatment Mrs. C. complains about daily, frequently unbearable headaches, about sleeplessness, recurring dreams of persecution, and extreme dejection. Her hatred and anger are, at times, so strong that she feels like tearing herself to pieces. She cannot stand having anyone around her and soon becomes impatient when her sons and grandchildren visit her.

In January of 1944, the patient was sent to Auschwitz and was only

glad that her two sons, then 11 and 12 years old, had previously been hidden by the Belgian underground movement.

In the following sessions, the patient describes a police roundup in 1942, when a German soldier saved her life and that of her two sons. He told the Gestapo that her house had already been inspected and was found to be free of Jews. To this day she dreams of those roundups in Brussels, when searchlight beams would shine through the night. Frequently intermingled with these dreams are similar experiences of a death march in 1945.

During the fourth hour, the patient is questioned about her childhood. She states that she respected her parents, but did not feel close to them. She cannot remember them ever kissing her. Her relationship to an older sister and three younger brothers was not close either. Her father, an engineer, had been away from home for five years during the first World War, when he was a Russian soldier. Her mother cared for the children, but was strict. They grew up in a well-kept home.

When she was 17, she fell in love with Boleslav, a Catholic Polish officer. He wanted to marry her, but fearing the families' disapproval, she fled to Belgium. In Brussels, she married a cousin and gave birth to two sons.

Following a nightmare, Mrs. Esther C. talks in detail about her experiences in Auschwitz, where she had been working in an ammunition factory from January, 1944 until January, 1945. One day, one of the female Capos, a former prostitute, threw her to the floor, laid bricks all over her and then walked over them because, allegedly, the patient had not worked enough. On another occasion, she was given 25 whiplashes which left her unable to stand up or work. The following day, some S.S. officials examined her in the nude and she had to say that she felt well, lest the female Capo should kill her. She was constantly afraid of a machine failure, due to poor working materials, and of being accused of sabotage—which would mean death. She hated the female Capos and wished they would die.

During these detailed recollections, the patient suddenly remembers medical experiments that had been performed on her. She asks: "Am I dreaming? Am I crazy?" and recalls that doctors in Auschwitz had sewn tablets under the skin of her thigh. It felt like stone and she had to keep touching the skin area. After the liberation, although she had forgotten the incident, she told her husband: "I am dead; I am no longer a woman." She never had any bodily contact with him again. She refuses to think or speak about sexual feelings. In her youth she had considered sexuality an immoral topic. She had thought it most important to be respected as a "decent girl." Now, remembering and talking about the

experiment, the patient becomes nauseated at the thought, and at the same time filled with anger.

A few sessions later, in November, 1964, the patient admits that she has at times been very angry with God for permitting all these cruelties. She often tells God: "Stop treating me like this. You have punished me enough." She is so angry that she keeps dropping things, hurts, and burns herself. Sometimes she shouts: "I do not believe in you anymore!" But she feels that she has faith in God nevertheless, and trusts he will punish her torturers as he did Eichmann. Then she asks God to forgive her for accusing him. She is convinced that she survived only because God had protected her. Thus she survived the death march from Auschwitz to Ravensbrueck in January, 1945. An elderly German soldier helped her when she broke down, and he even gave her a piece of bread. It seemed to her as if heaven had sent him. During the selection in Auschwitz-Birkenau, she ran after her friends who were being loaded onto a truck. Dr. Mengele, the "Black Angel of Auschwitz," sent her back to the other side, thus saving her life. She just cannot understand all of this.

During the further course of therapy, the patient is willing to report details of her childhood. She remembers a maid, Manja, who cared for her from birth until she was eight years old. When dismissed, Manja was very sad, took the patient into her arms and cried. But the patient took it as something she herself could not change. According to her, it is weak to show any emotion. She is convinced that her survival in concentration camps was due only to this attitude.

In connection with another nightmare in which she dreamt she couldn't catch her breath, the patient makes associations to an occasion at the Ravensbrueck concentration camp when she was looking for some bones in the garbage can and a guard pushed her in and closed the lid over her. She cowered down there until the next morning, constantly in dread of suffocating. Since liberation, she has been afraid of going to sleep because she fears something might happen to her. Whenever there is a knock at the door, she cannot help thinking the Gestapo is coming. She has frequently insulted her neighbors and suspected them of being Nazis.

She feels she "died in Auschwitz several times a day," especially in the morning and late in the evening when she had to pass the S.S. commandant at the gate. Each day he would pick prisoners out of the gang and send them to the gas chambers. In a dream about blankets, the patient associates that she stole her blanket back in Auschwitz. On the death march, this blanket and a tin cup and spoon were her most valued possessions. She always kept them tied together and wore them around her waist, lest they be stolen from her.

During her sessions in March, 1965, the patient talks about terrifying dog faces and dreams about cats. In Auschwitz, the S.S. often ordered dogs to chase prisoners. She dislikes dogs, but is even less fond of cats. Therefore, she cannot get herself to visit her daughter-in-law and her family on Sundays as there is a "fat, black, ugly cat" in the house whose presence creates feelings in her of being unable to swallow. When it is explained to her that a cat often symbolizes the female genital, the patient recalls that, following her admission to the Belgian concentration camp in 1943, she was examined by the German Secret Police. She felt such shame that she has never mentioned it to anybody. She believed that the fat S.S. soldier was going to rape her, and she defended herself; thereupon, he kicked her down. She was then forced to undress and the S.S. soldiers examined her front and back with their flashlights. She was frightened to death and so ashamed that she felt the other prisoners would detect this shame in her face. Later in Auschwitz, she frequently ran around nude or half dressed like all the other inmates. After her liberation, she had lost all feelings of shame and exposed her breasts to an officer in Brussels to explain to him that she needed a brassière. Never before or thereafter did she undress in front of her family. The patient emphasizes that she is a "fanatic moralist" and feels ashamed to talk about these experiences.

The psychodynamics derived from the patient's material might be sketched as follows: Even in her early childhood, due to the strict and orthodox surroundings, the patient started to repress and deny her libidinal and aggressive instinctual drives. The lack of emotion when her nurse, Manja, was dismissed, is indicative of that process, as was her later decision to sacrifice her beloved friend Boleslav because of religious and social rules.

Mrs. C.'s marriage was a correct one, but she was incapable of experiencing any deeper happiness due to her inhibitions and defense mechanisms. However, she felt attached to her two sons. The enforced separation from them during the war caused the first deep dent in her inner wall of defense. The experience of the concentration camp shook the pillars of this inner structure. The forced regression to preoedipal levels led to apathy, lack of basic trust, disturbance of time experience, estrangement, and to a marked diffusion of aggressive and libidinal drives. For a short period following her liberation, infantile narcissistic and exhibitionistic traits appeared in the libidinal sphere, but were soon repressed by reinforced defense mechanisms. The deneutralized aggressive drives, however, broke through time and again. The patient hated not only the S.S. and the Germans, she hated the whole world and even God who had permitted such cruelties. In turn, these accusations against

God caused guilt feelings, forced her to punish herself, and increased her dejection.

Besides a chronic reactive depression (Strauss, 1957), the patient suffers from chronic reactive aggression and hate addiction (Hoppe, 1962). Her feeling of being chosen, the constant externalization of a negative conscience, her identification with the aggressor, frequently accompanied by hysterical traits, as well as a marked process of resomatization, fit into the symptomatology of a chronic reactive aggression.

The Therapist's Reaction

From the beginning, the therapist makes the connection between recollections of suffering in the concentration camp, childhood experiences, and the patient's present condition. He is using treatment motivation (Hacker, 1962) and some aspects of working alliance (Greenson, 1965). The therapist is frankly interested in her experiences in the concentration camp.

During later sessions, the patient is asked several times whether she rejects the therapist because he is German, or whether she considers him a Nazi. The patient denies both, with a smile. On other occasions, she blames the therapist for forcing her to recall painful material. She emphasizes that she suffered enough and prefers to be insensitive and dead.

The Therapeutic Situation

The patient's resistance becomes apparent not only in the above mentioned statements but also in her fixation upon psychosomatic symptoms and her urge to leave the doctor's office prior to the end of the session. Avoidance, denial, repression, and projection turn out to be the essential defense mechanisms which are employed time and again by the patient, due to repetition compulsion and self-punishment. Simultaneously, with the decrease of resistance, hysterical symptoms appear in the foreground, while paranoid feelings, depression, and aggression fade away.

The patient's dreams reflect her condition during the treatment and the change of resistance. While during the first month she is flooded with dreams of persecution, she states angrily, in March, 1965, that she cannot remember any dreams but only wakes up tense and frightened. In April, 1965, she remarks that she had a happy dream, the first one for over 20 years, but cannot recall the content

of it. Simultaneously, with this change she experiences the therapeutic situation as more real, and not as much like a dream as before.

Resulting Modes of Behavior and Structure

Concerning the transference, there is little noticeable in the beginning except for fugitive "hovering" transference reactions (Glover, 1955). Strong distrust, defenses against primary anxiety, and hatred, are predominant and overwhelming. Remembering Boleslav, the patient smiles for the first time and reflects feelings of a deep emotional involvement. From then on, positive aspects of transference become apparent.

A remarkable concentration of transference reactions was produced by a Christmas gift. The patient reports that at first, for a minute she rejoiced at the new sweater because she had wanted one like that for a long time, but had never been able to afford it. Right afterwards, she says she felt deeply unhappy and depressed. It had shocked her that people should really care about her. This thought hurt her like a beating on the head. Since her stay in Auschwitz, she had been convinced that people are more or less beasts, and that she could not really trust anybody. From then on, the patient wore her sweater to every session. Not the gift itself, but the acceptance of her ambivalent feelings about it and the interpretation which followed it, seem responsible for the increase of positive transference feelings. This development helps the patient overcome her distrust.

Following the dream about the blanket, she mentions a doll. Upon request from the therapist, she brings the doll to the session. It is a tiny, funny looking boy-doll that reminds the patient of her grandson. She caresses it furtively several times during the session. The acceptance of this secondary transitional object (Winnicott, 1953; Stevenson, 1954) and of the patient's regression connected with it, increases the transference neurosis, which is of an oral nature. Simultaneously, it is used for reality testing in the therapeutic situation (Hoppe, 1964).

Although the treatment is in no way completed, we can say that the patient has diminished her mistrust, apathy, estrangement, and diffusion of instinctual drives, as well as discharge of deneutralized aggression. Recently, Mrs. Esther C. spontaneously states that she is able to distinguish between "good" and "bad" people, and can trust her relatives and the therapist. She seems to face the yet unsolved

conflicts and revived crises of the anal and oedipal phase in a more favorable condition.

In January, 1966, however, Mrs. Esther C. felt compelled to discontinue her treatment (84 sessions) because of the complete lack of financial support from the German Indemnification Office.

CONCLUSION

Based upon these two illustrative cases, as well as on the histories of other survivors treated in our clinic, I should like to outline and summarize the most significant psychodynamic factors (Hoppe, 1966) concerning the patient and certain requirements on the part of the analyst:

A) On the part of the patient:

1. The lack of basic trust (Erickson, 1950) which has been destroyed by the concentration-camp experience combined with hopelessness, helplessness, apathy (Greenson, 1949; Strassman et al., 1956) and a standing still of time experience (Hoppe, 1962).
2. Since a regression to early infantile behavior was forced upon the patients in the concentration camp (Cohen, 1953; Engel, 1962), the therapeutic regression (Benedetti, 1964) is rendered more difficult.

The uniquely inhuman experiences of the concentration camp lie beyond the "polymorph-perverse" experiences of the child. These regressive states are therefore frequently of a delusional, unreal quality.

3. There is a fixation upon early identifications and the "negative myth" of the concentration camp which frequently occurs simultaneously with an idealization of the patient's own childhood (Chodoff, 1963).
4. Avoidance, denial, repression, and regression are the most frequent defense mechanisms. The severe guilt of the survivor (Trautman, 1961; Niederland, 1961; Krystal, this volume) can, at times, be traced back to infantile guilt feelings caused by death wishes toward parents and siblings, as it is shown in the first case history.

Furthermore, conflicts and crises of the childhood are sometimes covered up by aggressive and revengeful fantasies to-

ward the torturers (Hoppe, 1962, 1965). A further determination for the guilt feelings seems to lie in the severe conflict between the instinct for self-preservation and family ties.

5. Frequently deep-rooted disturbances of the body image are found together with depersonalization (Pedersen, 1949; Jacobson, 1966), diminished cathexis of ego boundaries (Federn, 1952), resulting in a loss of self-esteem (Bibring, 1953), resomatization (Schur, 1955) and conversion (Rangell, 1959). It seems highly probable that these disturbances are due to the enforced shift of the body cathexis in the concentration camp (Niederland, 1964) and the violent extortion of any sense of shame (which was the case especially in our second patient).
6. There are disturbances in the development of superego, through destruction of the ego-ideal and a fixation upon a masochistic-submissive attitude (see our first patient) (Berliner, 1958; Chodoff, 1963). The aggression is either turned against the patient's own self, thus increasing the depression, or is focused as "hate addiction" upon an externalized negative conscience (Hoppe, 1965).
7. The sociocultural background of the victim has to be taken into account. The Jewish family life in a small East European town (Zborowski and Herzog, 1952) furnished valuable clues especially for the development of a strict superego, which was shown in our first case study.
8. There was frequently no adaptation to or rerooting in the new home country. The "neurosis of uprooting" (Pfister-Ammende, 1961) and the revival of oral wishes (Krystal and Petty, 1963), already noted in refugees and immigrants, often intensified the disturbances caused by the concentration-camp experiences.

B) On the part of the therapist:

1. He is required to show attentive consistency, empathy, and compassion without being overwhelmed by his own feelings of sympathy.
2. His permanent interest in the patient's motivation (Hacker, 1962), the transference neurosis, and the working alliance (Greenson, 1965) is essential.
3. He must firmly work through the patient's resistance (Freud,

1958a, 1958b), which is particularly expressed against the association of concentration-camp sufferings and childhood experiences.

4. He must constantly seek a fruitful and balanced relationship between abstinence and gratification of the patient's needs.
5. He must listen patiently to repetitive recollections of cruelties, dreams of persecution, and encounters with death.
6. He should openly admit his mistakes in treatment (Freud, 1938, 1964) and be constantly attentive to the countertransference.

These principles, basic for every psychoanalytic treatment, are of particular significance in psychotherapy with concentration-camp victims. Their observance is instrumental in overcoming the initial doubt that human beings exposed to such extreme cruelties can be helped.

It seems especially important that the therapist work through his own guilt feelings, which may be the result of his life in Nazi Germany, or his lack of open resistance inside or outside of Germany. His guilt feelings become evident, for example, if we find him reporting his own sufferings under the Nazi regime (Meerloo, 1963a) or by evading the patient's recollections of cruelties. The therapist should constantly be prepared to be identified with the aggressor, and to scrutinize his own tendencies to give in to the patient's demands as a reaction-formation. We found that it is possible to overcome the patient's prejudice which, though having its nucleus in reality, has been widely inflated by generalizations, projection, and externalization.

A basis for improving the victim's condition lies in the realization of these psychodynamics and the consideration of resistance, transference, and countertransference. Our own therapeutic experiences (Hoppe, 1965-66) are quite encouraging—even if Jahoda's (1958) six criteria for the psychological content of positive mental health are applied—and correspond with the results of Niederland (1964), Trautman (1961), and Edith Ludowick Gyomroi (1963). Tas (1951) arrived at the same conclusion, giving psychotherapy in the concentration camp. Friedman (1949) and Bastiaans (1957) reported improvement and changes through psychotherapy a few years after liberation.

The psychodynamics of survivors of German concentration camps, and the experiences in treating them may also help us understand other groups of human beings who were exposed to extreme environmental stress. Several comparative studies, i.e., by v. Baeyer, Haefner, and Kisker (1964) and Eitinger (1964) showed certain characteristics and differences between concentration-camp inmates, resistance fighters, and prisoners-of-war. Undoubtedly, the extent of massive stress, the age, and the nutritional state play an important part (Hocking, 1965). Decisive, however, is the inner experience and reaction of the individual to the complete deprivation of any security and dignity. Venzlaff (1964, 1966) found that victims of racial persecution outside of the concentration camps suffered from exactly the same aftereffects as did inmates of the camps.

It is our hope that the presentation of the two case studies may contribute to the general understanding of the late sequelae of massive psychic trauma.

INITIATION OF PSYCHOTHERAPY WITH SURVIVORS OF NAZI PERSECUTION

DR. TANAY, M.D.

Twenty-three years after the victims of Nazi persecution have been liberated, we are confronted with a striking discrepancy in the psychiatric literature. On the one hand there is an ever-increasing amount of literature describing the psychopathology resulting from the exposure to extreme psychic trauma; on the other hand, there is practically no literature on psychotherapy with survivors of Nazi persecution.

Another striking observation, and related to it, is the fact that very few survivors are receiving psychotherapy. This is astonishing if we accept the well documented fact that nearly all survivors suffer from some psychological disturbance (Krystal & Niederland, Chapter 10, this volume). Practically all victims of Nazi persecution are living in large urban centers, where psychotherapy is readily available. They have come to this country under the auspices of the Jewish social agencies, which are known for their psychological-mindedness. The Jewish hospitals in the urban centers have well developed psy-

chiatric departments, with a great deal of psychotherapy being conducted independent of financial considerations. Furthermore, in recent years many survivors have received pensions from the German government which may include financing of psychiatric treatment, if specifically authorized. Given these factors, one would expect a high incidence of psychotherapy to be rendered to the survivors. Among the hundreds of survivors I have evaluated for the German Consulate, there has not been a single case of psychotherapy. I did find four cases of involuntary hospitalization for acute disturbances, but not a single case of continued psychiatric treatment. Informal inquiry among psychiatrists in Detroit revealed a handful of cases in treatment. Of the 23 survivors with whom I have had psychotherapeutic contact, only two have come for therapeutic consultation which developed into psychotherapy. What accounts for this discrepancy between the high expectancy of psychotherapy and its low actual incidence? These observations are perfectly consistent with the very nature of the symptomatology manifested by the survivors. As it has been pointed out by Krystal, Niederland, Venzlaff, and others, the survivors have undergone a "personality alteration," most often characterized by masochistic defenses.

Krystal (this volume) points out the inadequacy of the old term "traumatic neurosis," for this population. All clinical workers in this area seem to agree that the survivors show characterological changes which essentially represent this persistence of reality-oriented adaptations. The term "adaptations" is preferable to the term "defense" to emphasize the fact that these phenomena developed in response to the demands of external reality. Freud (1924) pointed out in "Neurosis and Psychosis" that "it is always possible for the ego to avoid a rupture in any of its relations by deforming itself, submitting to forfeit something of its unity, or in the long run even to being gashed and rent." It is characteristic of the survivors that they had strong ego defenses which did not permit nonadaptive discharges. Regression and deforming of the ego were the only reality-oriented adaptations available to the people living in the "psychotic culture" (Wangh, this volume) of Nazi persecution.

In traumatic neurosis there is a conflict-"solving" symptom which makes it possible for the individual to function essentially on the same level of maturation which prevailed prior to the exposure to trauma. Working with the survivors, one is impressed with the degree

of regression of the defensive organization. The predominant defenses are: denial, isolation, and somatization. All three mechanisms have in common the fact that they lead to egosyntonic personality changes. It should be emphasized that I am referring primarily to a lack of symptom-awareness when I speak of egosyntonic changes. Considering the aspect of the psychopathology of the survivors, the term "traumatic state" might come closer to conveying the essential nature of the symptomatology. The recognition of this characteristic is of paramount importance in successful initiation of psychotherapy with victims of massive psychic trauma. It has been my experience that overt requests for treatment on the part of the survivors are extremely rare. They will present themselves for a variety of reasons, but almost never with a conscious desire for treatment.

The second factor which accounts for the low incidence of psychotherapy among survivors is the attitude of physicians, psychiatrists, and the bureaucratic machines toward victims of psychic trauma.

For the last eight years, I have been a consultant to the Veterans Administration Regional Office in Detroit. Over and over I was impressed with the fact that psychic traumatization is either not recognized or is minimized even in the V.A. The conventional approach to psychic trauma prevails and is characterized by the assumption that the patient is malingering, or at least exaggerating. The manifestations are expected to fall into the category of some well-known clinical entity or, on the other hand, there is the common sense view of response to psychic trauma. This could be paraphrased as follows: an individual is overwhelmed by stress; he undergoes an "emotional shock" for a certain length of time, but given some rest and support he recovers fully and is enriched by interesting experience, which he can exploit in conversation and/or demands for compensation. It has to be recognized that the concept of psychic trauma is relatively new. Furthermore, it should be emphasized that a descriptive psychiatrist does not deal with the dimensions which are primarily affected as the result of massive psychic trauma.

One can perform a "mental status examination" on a concentration-camp survivor and find none of the traditional signs and symptoms of mental illness. The psychopathology may be hidden in characterological changes that are manifest only in disturbed object relationships and attitudes toward work, the world, man, and God. One discovers hidden anxieties or guilt feelings in a psychotherapeutic

relationship, or in pursuing the dynamics of the patient's dealing with his reaction to the massive assault, loss of security in his home and family, reactions to murder, uprooting, or migration. For these reasons, the seemingly absurd situation has persisted that certain psychiatrists, especially those who are organically or descriptively oriented, consistently find no psychopathology in the survivors of Nazi persecution, while psychodynamically oriented ones, who look out for the fate of the patient's instinctual, defensive, and characterological defenses, consistently find a plethora of problems and symptoms. The former are driven to the cynical definition of emotional trauma as "a state of mind precipitated by an accident, stimulated by an attorney, perpetuated by avarice, and cured by a verdict" (*Time*, February 14, 1964).

The difficulties in initiating psychotherapy are derived from the essential psychic structure of the traumatic state. It has already been pointed out that direct requests for treatment are the exception rather than the rule among the survivors. The survivor has to be "seduced" into treatment by the therapist. Some years ago, when I first became active in making evaluations in connection with the claims for compensation for damages sustained to health, I was approached from time to time by survivors who have already been given a compensation award by the German government, which usually included reimbursement for treatment. The proposal would run as follows: "They (the Germans) say that they will pay for my treatment. Since I don't need it, why let them get away without paying after all they have done to me and my family? You, doctor, give me a bill for treatment and we will split the money." The self-deceptive nature of such requests was quite transparent, and I would attempt to point out that the individual was, in fact, in need of treatment and was attempting to cheat not the German government but himself. The session would end in an angry exit by the patient, who at times would accuse me of being "on their side." I felt a great sense of frustration since here were people in desperate need of treatment coming to my office and yet I was unable to reach them. This frustration was even more pronounced when I discovered that the great many survivors whom I saw for official evaluation, and whom I advised to seek treatment and referred to carefully selected colleagues, rarely if ever did remain in therapy.

It was quite obvious that some modification of the traditional

initiation of treatment was in order. The transition from the old to the new approach occurred for me with the case of a patient whom I shall call Mrs. Stein. She is a woman in her middle thirties, whom I examined for the German Consulate in 1961. She spent her childhood in the Ghetto Lodz and her adolescence in Auschwitz. She suffered from a very pronounced survivor syndrome which I described in my report. A year after the evaluation, the patient returned to inform me that she did receive a pension based upon my evaluation and also the commitment that she would be reimbursed for treatment. She then proceeded to make the usual "let's cheat the Germans" proposal. This time, I listened with interest and was careful not to make any definite statements. Whenever the opportunity presented itself, I used it to ask questions, explore difficulties, and offer advice. Our time was up and Mrs. Stein graciously agreed to see me again. What followed was five weeks of similar appointments, without a definite statement about the "business deal." I never committed myself in either direction, but as far as the patient was concerned she was working on the deal and not working in treatment. In the sixth session, I made a straightforward statement that I gave this matter considerable thought and decided that I could be either her business partner or her doctor. Since I felt that she needed a doctor more than a business partner, I would therefore have to reject the deal and would see her as a doctor, in treatment. My statement precipitated an angry outburst; nevertheless, Mrs. Stein kept her next appointment and has been in treatment ever since.

"Let's cheat the Germans" is a frequent opening gambit which, in fact, is a desperate cry for help. I recall another survivor, a man in his late thirties, who never applied for the compensation money and therefore could not avail himself of "let's cheat the Germans" technique. He was a profoundly depressed man who, in spite of his considerable financial success, was living in a one-room apartment and had no friends whatsoever. He presented himself with a request for a statement to be attached to his will, indicating that he was of sound mind. He was concerned that his will might be contested, although it did not contain any unusual provisions. He already had such statements from two psychiatrists, but felt that a third one was needed. The two other psychiatrists whom he had visited in connection with this matter did not recognize the plea for help behind the very plausible story as to why he did need such statements. We had

three appointments about various versions of the statement, but also managed to discuss his chronic depression and his failure to apply for compensation. In the course of these sessions, he realized that he needed help. It became apparent that one of the reasons these patients are driven to deny their emotional damages is that to admit them would, in their minds, represent a victory for their Nazi persecutors.

The inability of the survivors to make an overt request for treatment is matched by the reluctance of therapists to have such patients under their care. Even a one-time evaluation of survivors is very stressful for the therapist, and therefore professional contacts are consciously or unconsciously avoided. Let me emphasize the fact that a session with a concentration-camp survivor is, of necessity, an intensely stressful experience for both of the parties concerned. Failure to accept this as a fact will interfere with the progress of treatment, or the quality of an evaluation. To be emotionally drained and distressed following a session with a survivor is not a sign of an antitherapeutic overinvolvement, but a natural reaction to a realistically stressful situation. A properly handled hour with a survivor becomes a cathartic experience for the patient, and therefore has an emotional impact upon the therapist. The modern psychotherapist is rarely exposed to this type of interaction, and will defend himself against it.

A competent psychoanalytically trained psychiatrist called me once late at night, distressed by the following situation: he saw for evaluation a young woman who at the age of 12 was incarcerated in Auschwitz and lost all of her family. She filed a claim for compensation for damages sustained to her health, and presented herself for an evaluation. My colleague conducted a thoroughgoing evaluation and found no evidence of psychopathology. The findings and the history seemed to this intellectually honest man to present a discrepancy. He asked me if I could see this patient in consultation. My own evaluation revealed a typical concentration-camp survivor syndrome. The patient, a very attractive young woman, presented at first a nonchalant picture. As far as she was concerned, there was nothing wrong with her. In fact, the war had strengthened her character to a point where she could handle anything in life without much difficulty. Her success in the easy-going world of today was assured by the strength of her war-developed personality. In spite of her apparent health, she felt I should give her "a good report"

since after all, she did suffer a great deal from the Germans and "why shouldn't they pay?" We continued in this vein until I asked a seemingly innocent question about the area in which she was living. At this point, the patient looked perplexed and then burst out crying, mumbling something about the "smell of barbecues." From this point on the interview changed drastically. The smell of barbecues was, to her, reminiscent of the smell of burning flesh in Auschwitz, and the mere mention of it broke through the defensive veneer. This is a well familiar pattern for the evolution of an interview with a survivor. In countless evaluations and therapeutic sessions, a similar process was repeated over and over. The defensive posture of denial and evasiveness would dominate the scene at first, then something would come up which would break through the repressive barrier, and the flood gates would open up for emotions so intense that they were threatening to the patient's homeostasis. Whether such a development would take place or not would depend on my attitude and receptiveness. On the days when my capacity to endure such a session was very low, the patients obligingly maintained their defensive posture. I know of no question or technique which will automatically turn on this process of expression and catharsis. But there is nothing easier than to turn it off. One question or even a glance which is "out of tune" and the "psychological closing off" (Lifton, this volume) is re-established. A single evaluation or years of psychotherapeutic sessions can be conducted under the protective mantle of "psychological closing off" by the therapist, which is identical with the patient's defenses against the overwhelming experiences in the holocaust.

The personality and feelings of the therapist play, in treatment of the traumatic state, an even more controlling role than in conventional psychotherapy. The sensitivity and intense perceptiveness of the survivors will unmask quickly countertransference reactions on the part of a therapist. Fluctuations in attention of the therapist are picked up by these patients with readiness and pathological hypersensitivity seen in schizophrenics and certain character disturbances. Meaningless supportive remarks are experienced as insult, and thrown at the therapist with a vengeance. A patient was describing, with feverish intensity, being sent to a certain camp. Trying to lower the emotional pitch, I asked, "Where was it? In the Ukraine?" He looked at me with contempt and said, "Doctor, what do you want

to know about—Russia or me?” He perceived the reason behind my seemingly appropriate question: I was defending myself against the overwhelming outpourings of affect. I was attempting to block the flow of material, based upon my own needs.

The treatment of a traumatic neurosis or a traumatic state cannot be fruitful if the patient maintains the defensive posture vis-à-vis the therapist, or if the therapist cannot tolerate the stressful nature of the therapeutic sessions. It is my opinion that if the initial sessions produce no periods of communicativeness manifested by production of appropriate affect, the treatment should not be undertaken by this particular therapist with the given patient.

The lack of effect of intellectual insight upon function becomes quite apparent in patients of traumatic state. Most of the survivors have considerable intellectual understanding about the origins of their psychopathology. One is impressed with the degree of connection the survivors make between their symptoms and the precipitating events, and yet this intellectual knowledge has no influence upon the symptomatology.

Case Illustration

The extent to which both patient and psychiatrist will go to avoid dealing with the experiences of extreme traumatization is well illustrated by the case of Mrs. F. The patient, a 34-year-old woman, was seen in 1962 for the German Consulate for the purpose of determination of her disability. The chief complaint she offered was “dying attacks.” She described very vividly these episodes which begin with a heat wave, followed by inability to breathe, accompanied by severe gastrointestinal cramps like something is about to happen—“something has to come out and it cannot.” She then would begin to scream, felt as if she were going to die. On many occasions, the fire department had been called with a resuscitator because she appeared to the observer as indeed being in danger of dying. These attacks began immediately after liberation and the patient’s great hope in coming to the United States had been to find a “big doctor in America” who could cure her of this symptom. After her arrival in New York, she did in fact locate a “big doctor” who was attempting to help her with her problem, which she defined as “I cannot let go in my stomach.” She described the treatment as “washing her stomach out from both ends.” At this point, I might indicate that the patient is a rather naïve and unsophisticated person of superior intelligence, who had spent her early adolescence in the Ghetto Lodz and in Auschwitz. The patient always knew that the attacks could be inter-

rupted if, in the beginning stages, she received two or three enemas. This had to be done quickly, inasmuch as any delay would make the preventive function of the enemas ineffective. The "big doctor" improved upon the patient's therapeutic regimen through the use of complicated equipment.

I used the evaluation session to demonstrate to the patient her need for psychotherapy, and evidently succeeded. My recommendation that she should receive a pension and psychotherapy had been accepted by the German authorities. I found this out two years later when the patient presented herself in my office, stating that she had accepted my advice and secured psychiatric help after she was notified that the German Compensation Office would reimburse her for expenses. At the outset of her treatment, she informed the psychiatrist that she would talk about anything except the war experiences, and that he was to promise her that he would never bring it up. The psychiatrist accepted this condition and the patient saw him regularly for one year. At that point, the patient decided that "I should talk to him about the war even if it kills me." When she brought up the subject of her camp experiences, the psychiatrist stated that he never heard of the KZ camps. At this point, the patient noticed for the first time that the doctor had a large crucifix hanging in his office. The following exchange took place between the patient and myself:

Mrs. F: I went to my husband and told him he has a "ceylim" (crucifix) on the wall. Maybe he is not an American; maybe he is a German.

Dr. T: Could it be you thought he has the same problem you do?

Mrs. F: You mean, what I don't want to talk about, he doesn't want to listen to?

Mrs. F. began treatment with me and has made considerable progress. The "dying attacks" have subsided. She completed hair styling school. Recently, she was able to visit her sister in Israel, which represented an important step in her treatment.

There was also a dramatic change in the patient's marital relationship. The patient recognized the obvious implications of her husband's unfaithfulness and took effective action to terminate these activities. She also began responding sexually, experiencing occasional orgasms for the first time in her 17 years of marriage. These favorable changes have taken place after approximately two years of treatment, during which time the patient showed the defensive position characterized by an attitude of complaining helplessness, full of obsessive ruminations about her guilt in surviving—and in particular in "contributing" to the death of her favorite uncle. After the masochistic ruminations had been interpreted a great many times, the patient did go through a period of genuine

depression which was followed by the above described improvements. The turning point in the treatment of this patient was her enrollment in a school for beauticians, which was experienced by her as an aggressive undertaking, and was accompanied by considerable support from the therapist.

It has been my experience that if psychotherapy is to be successful, it must provide the patient with a realistic outlet for his aggressive strivings. A majority of the patients treated or evaluated reported the avoidance of activities which they perceive as aggressive and dangerous, but which simply represent self-assertion or attending to one's legitimate needs. Inability to drive is a very common symptom among survivors who have learned how to drive and then become unable to continue this activity. A considerable number of the survivors also reported an inability to learn how to drive. This inhibition appears to be related to the fear of losing control of one's aggression and is most common in women as a symptom of the dread of their destructive impulses toward their children. The resumption of driving was a definite sign of improvement and was actively encouraged. A great many survivors are engaged in work situations of a masochistic nature. I have noted that a considerably high percentage of survivors work as "peddlers" in slums. This is not only a dangerous but also a frustrating occupation, which consists of selling on credit and collecting two or three dollars every Friday. The collection rate is low and the number of physical assaults high. To test my observation, I have asked a wholesaler, who is the major supplier in Detroit for the door-to-door salesmen, for the statistics on the representation of survivors in this occupation. According to his data, 40 per cent of the peddlers in Detroit are survivors of Nazi persecution (the survivors' general proportion in the population is less than 1 per cent. Besides the low income, degrading nature of the work, and the danger, one discovers that some of the motivation for this choice of occupation involved an unconscious need to identify with the negative prototype for the Jew created by the Streicher and Goebbels propagandists. The efforts to bring about a change of occupation among some of these peddlers were rather unsuccessful, since too much masochistic gratification was derived from this type of work.

For the last three years, I have been conducting a seminar for the medical directors of automotive plants in and around Detroit.

Through the cooperation of these doctors, I have learned that a considerable number of survivors work as factory workers, usually in the lowest capacity: for example, as sweepers. These patients are described as "chronic complainers" and frequent visitors to the medical department. The experience has been that the survivors are a great burden to the medical department and no problem to the foremen. This pattern of reaction is very instructive in understanding the persecution-connected characterological changes in survivors.

Becoming a "sweeper" was an adaptive and desirable achievement in labor and concentration camps; it is, however, maladaptive for the present situation. It is therefore an atavism pathognomonic of the personality damage: it creates characterological deformation by endowing certain fears and regressions with the strength of compulsions. In other words, by becoming a "sweeper," they achieve these goals which were extremely desirable in the concentration camp: (1) to escape direct supervision by Capos; (2) to escape working on production (danger of being accused of sabotage and severe beatings); and (3) being "foot loose" is safer—you can run, you can "handle," "organize," buy and sell. The psychopathology is evident in the fact that they now act upon a situation which existed 25 years ago. To become a "sweeper" now accomplishes none of the objectives, and represents an imprinting of the character with an inappropriate goal because of the traumatic circumstances of the "extermination through labor." The peddler also shows an overcompensation of the fear of being closed up in the ghetto, with its terror and starvation related to the isolation and loss of mobility. When trapped in the ghetto environment, the greatest desire would have been to be able to escape and peddle in the countryside. The present-day survivor-peddler is still driven by an ancient anxiety; his job behavior is as symptomatic as that of the concentration-camp survivor who cannot go to sleep without a piece of bread under his pillow. Another persecution-connected occupational trend is noted in the shift from the small business mercantile occupation into the skilled trades such as carpenter, plumber, and tailor. People in these occupations also had a greater chance of survival under the Nazi regime. The malicious effect of the Nazi propaganda against Jews as businessmen seems to have had a lasting psychological effect.²

² Henry Krystal, M.D., personal communication.

Conflicts about aggression are the focus of almost every therapeutic session with the survivors. Most of the material presented deals in some form or another with the handling of aggression. However, the vicissitudes of aggression in the lives of the survivor is an area of considerable difficulty as far as interpretation is concerned.

Most of the aggression is tied up in masochistic attitudes, thinking, and behavior, expressed in death wishes or in constant ruminations about the dreadful past. Obsessive ruminations and repetitious dreams are, in my opinion, not only attempts at mastery but serve the gratification of masochistic needs. Frequently, they provide the only available channel for the expression of aggression. These patients need their nightmares in spite of the disruptive influence the dreams exert upon their functioning. It has been my observation that the same survivors are most reluctant to take tranquilizing drugs, and there are various reasons for this fact. One of them is related to the lessening of intensity and frequency of the nightmares under medication. The therapist has to develop a tolerance for the suffering of his patients. Vigorous efforts to alleviate symptoms in the initial stages will lead to an abrupt termination of the therapeutic relationship.

Case Illustration

In the early stages of her treatment, Mrs. S. suffered terribly from her dreams. She complained bitterly and described vividly the nightly tortures and the subsequent state of extreme tension and fatigue during waking hours. She was placed on tranquilizers and sleeping pills and began sleeping quite well; to her knowledge had no more anxiety dreams. She was unable, however, to tolerate this change, became profoundly depressed and discontinued the drugs herself, stating, "They are too strong for me." A year later, after some work in psychotherapy, she was placed on the same drugs and was able to accept the change brought about by them. In other words, Mrs. Stein had not only experienced the symptom of nightmares and the disruption of her functioning which followed, but had also utilized this very symptom as a defense against depression—through expiation of guilt by the nightly self-torture.

In traumatic states, being overwhelmed (emotional spell) has become a character defense, like anxiety in chronic anxiety states (Brenman, 1952). Seton (1965) refers to the use of an anxiety attack to cover a rise in libidinal excitation. In the survivors one observes

the use of an "emotional spell" to cover a rise in aggressive excitation and the concomitant depression. To put it differently, these patients maintain the external danger to avoid the intrapsychic threat of depression. They seem to be saying, "I am not depressed. I am still threatened by reality which prevents me from being depressed." Patients have said to me in so many ways: "As long as I live in a concentration camp, I do not have to experience a feeling of depression."

Mrs. S. was living in a house which was far too small for the needs of her family. The change to more adequate quarters was delayed until a Negro family moved in next door, making the acquisition of a better home a "realistic" necessity. Three days before moving, the patient visited the family doctor for a health statement for her daughter, and helped him discover an enlargement in her neck, which the doctor felt should be "checked out." The patient experienced this as diagnosis of cancer. During the first night in the new house, the patient awakened because of knocking on the door and she saw the figure of a German officer trying to get in and "take us away."

The new home was a psychological crisis which highlighted the masochistic defenses of the patient. The house was a fulfillment of long held wishes and stirred up intense guilt feelings. The patient recognized this in treatment and handled the crisis very well. The cancer phobia and nightmares subsided quickly.

Social, financial, and psychological improvement is threatening to the survivors and it is the therapist's task to help the patient cope with it. Because of "negative therapeutic reactions" (Freud, 1923), improvement is therapeutic dynamite which will disintegrate the treatment relationship unless recognized as such and handled with care.

The survivor's life is full of hardship and suffering, which provides much room for improvement. An innocent question by the therapist will expose the self-defeating character of a reality situation and, if the problems of guilt be lessened, may be followed by a more realistic adjustment.

Case Illustration

Mr. G. was part-owner of a small furniture store. He was selling door-to-door, and the majority of the people who came to the store were his customers, who would have bought the items anyway. The partner was

not contributing anything but time, and even that he did rather poorly. Mr. G. did not expect much from him, although he was driven to preserve the relationship.

In the therapeutic session, a few questions were asked to ascertain the picture. Mr. G. recognized the inequity of arrangements and dissolved the partnership, finally finding it possible to see himself as an independent businessman. Shortly afterwards, he discontinued his treatment.

Summary

To restate my point, it is my impression that because of masochistic problems and because the damages to survivors of Nazi persecution resulted in personality changes, they are not likely to present themselves with a request for treatment. If treatment is indicated, it encounters many threats, among which the recognition of illness itself threatens to overwhelm the patients with self-disgust and feelings of defeat and anger which are residual from the persecution. If that problem is breached, the difficulties in transference threaten disruption because of the regression involved in the adjustment to the persecution. For that reason, the patient's aggression is experienced as extremely destructive. The transference, therefore, implies the destruction of the therapist, or of the patient's self. Paranoid reactions or serious depressions with suicidal danger may ensue. If all these dangers are handled, the negative therapeutic reaction resulting from the patient's masochism threatens progress and sets serious limits to what can be achieved. If one does not pay attention to all these pitfalls, the patient must defend himself by keeping the treatment infrequent, short-term, or quitting prematurely—against psychiatric advice.

Considering the difficulties in intensive psychotherapy (and psychoanalysis) of the survivors of concentration camps and other massively damaged individuals, one appreciates the importance of limited-objective psychotherapy with them. Dr. Hope, in the preceding paper, seems to be doing short-term psychotherapy with special attention to the problems of aggression. I have previously alluded to the survivors who may require therapy because they are "wrecked by success" and develop anxiety for such reasons. Dr. Niederland, in this volume, has pointed out that the survivors' reality testing and cognition is so disturbed that they live in constant expectation of the return of persecution. Not infrequently, an accident or misfortune throws them into panic, because they take it as a "sign" of the return

of persecution. Bodily injury and loss causes difficulties with such great frequency that Drs. Krystal and Petty discuss these problems separately (Chapter 9). Dr. Krystal has also pointed out (private communication) that because of the very frequent problems of muscle tenseness resulting in head, neck, back, joint, and muscle aches, another worthwhile limited psychotherapeutic objective with some survivors is the achievement of muscular relaxation, as suggested by Wolberg (1965). This list of problems and situations which may require short-term psychotherapy is far from being complete.

However, emphasis must be made of the fact that such limited objective psychotherapy is essentially emergency psychotherapy: helping the patients to overcome one of the difficulties to which they are prone because of their past traumatization. Such therapy does not achieve a change in their personality or style of functioning. It rarely achieves a significant change in their earning potential, nor a diminution in the degree of industrial handicap. This issue has to be considered carefully, because we are not dealing with "Renten-neurose," but attending to selected psychiatric emergencies, or difficulties which are prone to develop in these damaged people. The difficulties I have discussed usually force a limitation of the objectives of treatment in the majority of the "survivor-syndrome" sufferers. Perhaps we must confine our activities to supporting and maintaining their usual pattern of function, or improving it in specific areas without accomplishing an improvement on all fronts.

PROBLEMS IN THE PSYCHOTHERAPEUTIC TREATMENT OF ISRAELI SURVIVORS OF THE HOLOCAUST

HILEL KLEIN, M.D.:

In our previous study (1963) we were able to differentiate four groups of survivors:

- (1) Hospitalized patients with long-standing hospitalization, usually severely traumatized during the holocaust, without friends or love-objects and without family after the liberation. These persons usually showed schizo-affective types of psychoses with depressive and paranoid features, relating to present experiences as if they were still in concentration camps.

(2) Relatively well-adapted individuals who, however, show liability to periodic severe reactions, even of psychotic proportions. Such maladjustment may be precipitated by a variety of events such as the Eichmann trial, anniversaries of the death of their relatives, or even being examined for or receiving any restitution funds. These people seemed to suffer from a depletion of their ego-resources, a low level of frustration tolerance, loss of feeling of security and "basic trust," as well as a seeming lack of motivation for self-improvement. Consequently, they are passive and fatalistic, living in isolation from society. We were impressed by the existence of correlation between the pseudopsychotic development and comparatively young age at the time of oppression, as well as the severity of isolation from next of kin during the long-standing traumatizing experiences. The events of Nazi persecution which threatened their survival also injured their psychological and biological integrity. In these patients we see premature aging, impairment of cognition, abstraction, and problem-solving. There is a low level of intellectual function with constriction of social interests and investments. Typical traits of this group are passive, fatalistic attitude to illness, as shown in the lack of motivation for change, and lower self-esteem, as well as a fear of relating to the past; lack of political interest; and somatization symptoms of anxiety.

(3) People marked by changes of personality in the sense of character neurosis, expressing itself in intrapsychic as well as in interpersonal conflicts, irrational fear of the future, survival guilt toward murdered members of the family, and subjective feelings of loneliness. In our experience it is obvious that survival guilt is also a way of working-through late mourning and bereavement for loss of beloved people and of restitution of lost human values, as well as restoration of one's own human image. The guilt feelings of the survivors of the holocaust serve as a means of identification with the destroyed world, thereby achieving a restitution by identification with lost love-objects. Similarly, both guilt and aggression serve to restore a feeling of justice and security in relation to the world.

The problem of guilt in survivors is complex insofar as it serves to turn the aggression inward, and thus prevents both overwhelming anxiety on the one hand and misdirected hostility on the other. It also seems to serve as means of survival in a chaotic world where all objects of love have been lost and where there are no people with

whom to cry and to share one's grief. This is in complete contrast to the denial and rejection of any kind of guilt by the mass murderers of every age. In this group we might also observe patients with mixed neurotic features, usually hysterical and depressive symptoms.

(4) Finally, from everyday experience it is evident that many individuals who have undergone the long-standing severe strain of the concentration camp, apparently function well and fulfill important tasks in social, as well as professional and civil life. The question, therefore, arises as to what may be the reason for the difference between these people and the other groups mentioned. Based on psychotherapeutic experience with these patients, we found that these people had similar problems of feelings of discontinuity in their personality, of change in values, and lack of basic trust. Their interpersonal relations were also characterized by aggressive tendencies. Their ego structure was marked by active mastering of their interpersonal and intrapsychic conflicts. During the period of stress in concentration camps, they had a greater facility for active mastery and for group formation. While this means that they constantly lost their friends and "buddies," they seemed to "close off" their reaction to the losses and would almost immediately seek out another partner-in-misery. Some in this group were able to participate in organized resistance, or to plan and even succeed in escaping. They did not succumb to the total subjection that lead to becoming a "musulman."

The latter two groups were subject to neuroses and personality changes which can be classified as character neuroses. These two groups seemed to be able to benefit from psychoanalytically oriented psychotherapy.

It appears that for the survivors of the holocaust who live in Israel, the everyday confrontation with problems of the holocaust makes repression and denial of their traumatic past very difficult. They are confronted with these problems through the different media of communication, newspaper and radio, which bring detailed news about processes of war criminals, political discussions, and decisions about relations with Germany. Moreover, living together with so many people who have shared the same tragic experiences, and the annual recurrence of Remembrance Day of every destroyed community, complicates any attempts at repression. On the other hand, the psychological state of our patients is influenced by the condition of our country, the political and physical threats to its existence. Liv-

ing as they are, in a country surrounded by hostile neighbors, the patients are able to displace their past hostilities and aggressions to current enemies, rationalize these feelings, and gain further solace out of being *active* in the present situation. Humiliated for life by being “victims,” they feel they must become active “fighters” for personal and group justice.

In dealing with the survivors of the holocaust, the problem of motivation for treatment requires some discussion. The vicissitudes of the patients’ dealing in their own minds with the events of the persecution, the desperate fight for survival, makes them reluctant to enter treatment for the following reasons:

(1) The survivors experience themselves as unique, in having “been saved” from destruction in the midst of a general catastrophe, and in a way to have “conquered death.” To enter treatment is to give up this special status and to view themselves as mental patients—not omnipotent, but on the contrary—damaged people. The infantile narcissism reflected in this theme is not verbalized readily, and creates one of the therapeutic paradoxes.

(2) One important reason for the persistence of the omnipotent feelings to date is that it serves as a defense against feelings of overwhelming loss and abandonment to death residual from the holocaust. Both aspects of the problem manifest themselves in transference resistances. The patient identifies his therapist with the Nazi aggressor and projects upon him his own cruel punitive super-ego as well. From this, in his regression, the patient may experience the therapist as his secret “guardian angel” who saw him through the perils of total destruction all around him.

The working-through of the problems of death and abandonment, and world destruction presents itself in various stages of the treatment, corresponding to various libidinal levels, as well as to the variety of fantasies that these events become associated with in the minds of the patients. On the level he first presents, the patient may express his disappointment with his environment and accuse his therapist of a lack of understanding, interest, and compassion. The dealing with the *fact* of their losses may not come for a long time later, and the guilt therefore may be long delayed. In this relationship they may deal either with their grief, mourning, and guilt at first, or they may deal first with the projections of destructiveness

upon the therapist. The fact remains, however, that with time and given the patient's ability to deal with the regression without being overwhelmed by it, one discovers that the destructiveness of the holocaust has imprinted their every impulse and level of cognition, including those of cannibalistic world destruction and other primitive fantasies. However, as the effect of the persecutions has been to lend these impulses the "stamp of reality," and as, at the same time, the security and resources of the ego have become impaired, not many of the survivors can be expected to be able to tolerate such regressions, such threatening ideas and impulses. I will try to illustrate some of the difficulties encountered in the treatment of survivors of the holocaust.

Following are examples of problems in psychotherapy. The case of Anna P., born in Poland, married and the mother of one daughter, demonstrates the problem of guilt:

Anna was born in Poland in 1921. She is the second child in a family of four children. Her father died when she was six years old. After completing the local gradeschool, she studied at Vocational Training School and later worked in her profession as a milliner. Her elder brother, who was seven years older, took the responsibility of earning a living for the family after the death of the father. He married when Anna was 16 years old.

In 1939 she was forced to work for the Germans and lived in a ghetto. In 1942 she was separated from her two younger sisters, who were killed by the Nazis. She and her elder brother were sent to a concentration camp. In the beginning of 1944, her brother was killed and from then on she began to suffer from obsessive thoughts and depression. During the last few months she was emaciated to the state of "muselman" and en route to Mauthausen she contacted typhus.

After her liberation she suffered from isolation and loneliness. A few months after her liberation, she married a man 12 years older than herself. After the birth of her child, her obsessive thoughts became aggravated and the very idea that her child could be killed made her attempt suicide. At the same time, she continued to be obsessed with her responsibility for her brother's death.

The immigration to Israel from West Germany did not change her emotional state and she showed no interest in her family and in her life and surroundings. She was hospitalized in the Department of Psychiatry in 1961 for a period of three months. During this time psychotherapy was attempted.

In the fifth session, she presented her guilt feelings and self-accusation for being alive while her brother was killed. She dreamt that her daughter accused her of killing the child's father. She associated this to her guilt for the death of her brother. The patient said, "*I must think it over every time I see you, and see how it happened. Maybe I am not guilty for the death of my brother. He had come to me and asked me if he should go with a transport to a work camp. I told him not to go. I thought of myself, about the hunger and what would happen to me if he left me. The next day an S.S. man beat him to death. Later, his friends taunted me with the idea that had he been sent away he could have lived. I cannot free myself of these thoughts. I am thinking about this all the time—at least three or four hours a day—until I go to pieces.*"

During this period she saw the therapist as her savior, especially when she learned that the therapist had also been a prisoner in the concentration camps. She developed an intense dependency, and attributed omnipotence to him. Her distress over her guilt and demands that the therapist forgive her reached an overwhelming intensity. It became necessary to interpret her transference resistance: namely, that she experienced the therapist with the same ambivalence which she had felt toward her brother.

During the next session she talked about her dependency on her brother and her submissiveness to him. She admitted her envy, which she tried to deny by doing manual and cleaning work for him. After her brother's marriage she felt deserted, lonely, unlovable, and unacceptable. She felt rage when she was alone and often wished he would die. In the concentration camp there was a time in the beginning when she felt her childhood ties with her brother were strengthened and she clung to him for security. The course of psychotherapy consisted of 36 sessions. The patient, however, showed no remarkable change either symptomatically or dynamically.

This patient is characteristic of Group I, as we described above. One cannot say that her guilt feelings were based entirely on fantasy, since the coincidence in the concentration camp can be experienced by her in such a way as to blame herself for her brother's death. The patient can not free herself from obsessions connected with her experience in the camp. These thoughts appear frequently and at regular intervals. During this time the patient enters a state akin to catatonic stupor, but is able to communicate her thoughts after the attack has passed. In her imagination, she goes over the scene of the S.S. man beating her brother to death; she sees his body

and face and hears his shrieks. After that, she hears and sees his friends who accuse her of causing his death.

The problem which confronted us was: what caused the patient to develop such a severe disturbance which bordered on psychosis? During treatment, it became clear that she had not been able to rid herself of ambivalent feelings toward her brother, who had been an oedipal figure for her. The self-punishment, the atonement for his death in the form of a compulsive illness, was thus dictated by her mental structure and specific dynamic factors. However, during treatment the therapist had to remember again and again that these guilt feelings have their background in a tragic and cruel reality. In her chaotic world it seemed that all her sadomasochistic fantasies had come true.

The patient hadn't killed her brother and hadn't even indirectly caused his death, but her ambivalent feelings toward him—feelings of envy and dependence—express themselves in the need for self-punishment in the form of recurring obsessions: "I killed him." She says about her brother: "I thought I would die of hunger if he would leave me and go to another camp. Therefore, I advised him to stay. And so I killed him." These feelings of guilt were so intense that they appeared in the concentration camp, possibly because this event occurred at the beginning of the camp experience and she had not yet developed the "robotlike" reaction so characteristic of a later phase in the camps.

After the prolonged state of depersonalization of concentration and refugee camps, after giving birth and forming libidinal ties with her daughter, she immediately became frightened that her aggression would get away from her and might kill her daughter as it "killed" her brother. By being overprotective, she tries to avoid all danger.

Another characteristic example was Rina. She was a divorcee, aged 26. She was an only child. At the age of 15 she came to Auschwitz. At the beginning of treatment, she declared that "she was happy when she left the house and was taken on a transport to Auschwitz, because this brought escape from the endless conflicts with her mother." She also declared that the years in camp "weren't so hard" compared to her childhood, but during treatment it became clear that the patient used negation mechanisms in order not to have to deal with feelings of shame and helplessness connected with her experiences in the camp. In Ausch-

witz she was forced to dance naked before members of the S.S. Later she lost her figure, the "divine image" as she put it, and became a "walking skeleton." Every male became, for her, an S.S. man, a sadomasochistic image from which only by promiscuity could one be saved. These memories of her humiliation as a woman seriously threatened to undermine her self-image. Therefore, the tendency to deny and suppress all memories from this period. This came to light also in her previous treatments by other psychiatrists.

The recurrent problem, therefore, was to deal with feelings of shame. She showed anger when she had to go back over experiences where she saw herself as being contemptible and deprived of humanity. The therapist had to focus his attention on the tendency to masochism and self-punishment. The Germans' aim was to dehumanize, but the patients repressed their feelings of shame and guilt by a state of depersonalization and specific regression to a state of aggression mixed with helplessness toward their torturers. Such patients relate about themselves with guilt that they "were beasts" and didn't feel anything.

These concentration-camp prisoners, in becoming robotlike, or automatonlike, did something more than what Lifton describes as "psychic closing off." Whereas psychic closure is adequate in dealing with overwhelming loss, the victims of persecution had to, immediately upon the destruction of their families and communities, deal with continuing threat to their lives from the very same aggressors. In order to stay alive they had to avoid an open clash with their oppressors. But this situation compromised all of one's devotion, and involved a humiliation of such profoundness that it matters little whether the patient was forced to just dance before the S.S. men or was also raped. The fact is that reducing her to a work animal or tool of amusement was a rape of her soul.

Such a patient presents a problem of countertransference for the therapist. The therapist who faces suffering and life experiences of such magnitude is liable to have impulses to act out his own guilt feelings because he himself didn't suffer, or didn't do enough during the holocaust to fight the "evil." He may have to deal with nurturing impulses to turn into a good mother, one who gives and receives, without being able to relate to problems of aggression and guilt feelings in the patient. A frequent reaction to such countertransferences is the use of isolation mechanisms, intellectualization, or the use of psychoanalytic terms and generalizations taken from patient ma-

terial. These defensive reactions are the result of the anxiety of the therapist caused by the danger of traumatization with the patient's story, or as a response to the patient's projecting his anger and helplessness onto the therapist.

Another case in point is Reuben, born in Poland, 1926, married and the father of a three-month-old infant. He was sent to psychotherapeutic treatment because of functional disturbances in the form of hemiparesis in the right half of the body, headaches, and other physical complaints. About a half year before the beginning of the psychotherapeutic treatment, just after his marriage, there appeared a variety of diffuse fears as well as obsessions about killing his wife and others. After the birth of his son, these thoughts included the child and figures of authority such as his boss and the psychiatrist.

The patient was the second of two sons in a petit-bourgeois family in Lodz. After finishing elementary school he began to help his father in the carpenter shop and has been a carpenter ever since. When the war broke out and the Germans approached his home town, his father left the house and was never heard from again. The rest of the family, his mother, brother, and himself remained in the ghetto until 1943, when they were sent to Auschwitz. After a selection the patient and his brother were sent to a labor camp, and were separated from the mother, who was killed. A few months before his liberation, he was separated from his brother as well. Although he had become extremely run-down physically just before his liberation, he nevertheless was able to keep working and stay alive. After the liberation he was in a displaced persons camp until 1947, and immigrated to Israel at the beginning of the War of Independence. He was drafted upon arrival and took part in battle. In 1949, after his discharge from the army, he started to work as a carpenter and studied sculpturing in his free time. For many years he lived in a Bohemian fashion, sharing an apartment with two friends, until his marriage to an ex-officer of the Israeli Army at the age of 33. He began treatment in October, 1960 and concluded it in August, 1961, after 57 psychotherapeutic sessions.

In the treatment he presented himself as being an easy-going fellow who got along well, was friendly, passive, easily inclined to compromise, and an amateur sculptor. His ideal of himself was to be a "jolly fellow" and to be accepted by his artist friends. He had met his wife more than a year before the beginning of treatment. He had seen her as an image of success and authority, and married her against her parents' wishes. In our meeting, he pointed out that because he had told her about his physical pains and the enlargement of his heart, which was discovered

in the army, he and his wife had gone to a neurologist so that she could hear that he wasn't seriously ill. He complained that his wife was the dominating figure at home who nagged him and was demanding.

Three months after their marriage, while bathing together in the bathtub, he first had compulsive thoughts that he wouldn't be able to restrain himself and would hit her in the stomach. Since then his anxiety has deepened. He was very anxious and depressed, especially when he had obsessions with aggressive contents toward his son, whom he dearly loved.

The patient remembered that in his youth he was always compliant and submissive, given to daydreaming. His father called him "sleepy" in contrast to his brother, whom he remembered as an aggressive child, lacking self-restraint, talented, and loved by the father for these attributes. These tendencies were intensified during their stay in the ghetto when the two brothers remained alone with the mother. The brother would beat him and his mother mercilessly and would steal food. The patient had felt attracted to him and used to like to be with him before, but now he began to hate and fear him. He stated that his brother was capable of "killing a fellow who opposed him." He recalled with resentment that in their youth his brother never wanted to play or be together with him, and also that in the ghetto and the camps this brother fled from his company constantly. He remembered that he protected his mother from the blows of his brother. These subjects were touched upon in our first sessions and the patient returned to them all during the treatment; at first angrily, and afterwards accompanied by guilt feelings and self-punishment.

In our third session, when talking about his father-in-law as being, in his eyes, a repulsive and penalizing figure, he associated his relation to him with the relationship to his own father. He remembered that at the age of seven his father had beaten him severely, and for no reason, instead of his brother. At the time, the patient considered himself "finished" and did not expect to live or breathe again. As a result of this trauma, all his ambivalent feelings toward his father came to light. On the one hand, there was a yearning to be accepted and loved by him; on the other hand, there was resentment toward him because he obviously preferred the aggressive and talented brother.

In our fifth session, he stated that his aggressive feelings toward his wife had increased and such compulsive thoughts as "to kill her with a knife"—"to give her a blow with a board" appeared especially when he saw in her the dominating figure who aroused inferiority feelings. He felt that her attitude toward him was that of an officer, "like an S.S. man." He accused her of arousing feelings from his childhood which he

had been able to overcome after his liberation from the concentration camp, and pleaded that I restrain him and prevent him from murder.

In our eighth session, he related in detail his dependence on and submission to his father. He told how the father was demanding toward him, disappointed about him, and called him "Katzenkopf." He confessed that at the age of seven he had had death wishes toward his father, especially when the latter took his brother into his bed, whereas the patient had to sleep in the kitchen. Those desires were so abhorrent to his mind that he tried to "be better" and be accepted by his father, but to no avail. When his father fled from the Germans in the beginning of the war, the patient accused himself, without reason, of being the cause of his father's desertion. The guilt feelings came back in the ghetto, where he saw his suffering as the punishment for his death wishes toward his father.

Those memories of his father point to a fixation in an ambivalent relationship toward his father. The same complex is apparent in his relationship toward authoritative figures such as officers and his boss at work.

At the tenth session, he brought the first dream: his brother bombs him from an airplane and asks him to stand up as he has been given orders to kill him. He escapes in a fast car, shoots with a gun at the plane, and hits it in its tail. In association to the dream, the patient recalled a scene where his brother attacked his mother with a knife because she didn't want to give him some food, and the patient stood paralyzed in his place. Afterwards he defended himself from guilt feelings by saying that he hadn't attacked his brother, in spite of his being stronger, because he was afraid his brother would kill him. In the dream, he says, he wasn't afraid of his brother, but in reality had fears that the brother would return. He has daydreams in which he sees his father and his brother come back from the camps and he doesn't know how to act or what to say to them.

From our first meetings we could see a family situation in which Reuben felt that the authoritative father preferred the aggressive brother from early childhood. The patient repressed and negated his aggressive impulses. This repression caused a diminishing of activities and an upsurge of passive yearning, at first toward his father. In the course of the treatment, when talking about masculine characteristics of his wife, he related repeated homosexual experiences with his brother at the age of six or seven, and again in early adolescence. At first, he was the passive object of his brother's attack, but later on he enjoyed it.

Hate feelings toward his brother in the ghetto and his constant fear of being hurt or hurting, were topics which recurred during treatment

again and again. These feelings were now mainly projected toward his wife. He was afraid that she would attack him from the back, which we understood as a fear of a homosexual attack. The attempts at repression of aggressive impulses caused a regression with diffusion of libidinal and aggressive energies. The first attempt to develop meaningful libidinal ties made manifest feelings of repressed aggression toward his wife, who represented his brother. While he was in treatment, his wife left him, taking the child with her, after a violent quarrel. Thereupon, his death wishes for both became intensified, and he both wished and feared that his wife and child would "never come back," as his family had "disappeared." He identified his wife with his brother, regarding them both as "hotheads," aggressive, and dishonest.

In our twenty-seventh session, he related a dream in which he and his brother were together in camp. His brother said he couldn't stand it any longer and was going to commit suicide. The patient saved him and the brother asked why he did so. In the associations, guilt feelings were aroused because, on the last day they had been together in camp, his brother had asked him to be with him during selection and to work in the same commando, but the patient had refused and run away from him. He accused himself of abandoning his brother, and expressed the wish to atone for it. Thus, he displayed his emotions toward his brother, his rival, who was successful and loved by the father.

We then discovered that the impulse to kill his wife by kicking her appeared when they bathed together and he caught sight of her extraordinarily large clitoris, which he associated with his brother's penis. The masculine build of her body aroused attraction, anger, and revulsion—the same kind of ambivalence he had felt toward his brother.

The patient's memories of his attachment to his mother were not repressed, but handled by isolation. Still, we never did deal with his oedipal and preoedipal wishes toward her. In the transference, he related in his thirteenth session that he had told his wife to give him more food, using the doctor's authority to assert himself in this way. Thereupon, he related that his mother used to occasionally sneak him a little extra food while in the ghetto, in preference to his brother. Thus we discovered the oral striving in his mother-transference.

In connection with his application for restitution funds, he developed paranoid fears that the therapist and the government would prevent his obtaining any compensation. He revealed feelings of fear and suspicion toward "people in Israel" who he felt were cold and unfriendly to the "newcomers" (i.e., concentration-camp survivors). At the same time, he expressed the opinion that had the Israelis been in concentration camps they would have perished there.

DISCUSSION

In the cases presented, the intensity, duration, and objectives of psychotherapy had to be limited, and in one of the cases the attempt was given up after a trial period. I have tried to demonstrate how the aftereffects of the persecutions have become manifest in distortions of personality structure and the causation of specific symptoms and problems. Despite the difference in severity of the problems and the type of traumatic damage, the fact persisted that their persecution and mistreatment was the central factor in their emotional problems and their treatment.

And yet, their problems were so different. The first patient seemed to suffer from survivor guilt, and her feelings about her contribution to her brother's death seemed to override her reality testing just as her need for self-punishment overrode all of her other strivings. The intense masochistic problem rendered our therapeutic efforts useless.

The second case was one of reactive aggression, and the channeling of the masochism becoming associated with her femininity made her reject her sexual role and function. One further point is illustrated in her case: namely, that for her the aggressors all became men. To single out any specific group of men and direct the aggression to it artificially would be misleading for the patient. In this way, any preconceived notion on the part of the therapist would be a disservice to the patient. As a matter of fact, the patient did not find it impossible to work with a man, and chances are that had she worked with a woman therapist, her transference problems would have been just as reflective of her resentment.

However, in this case there was a shifting in aggressive energy, with an apparent quantitative change, as well as a disturbance in self-representation and object relations. Thus, she not only turned away from men, but from all potential love objects. It was this destruction of her "basic trust" that set the limits for a potential therapeutic alliance, and limited the degree of regression which she could tolerate. The point here is twofold: many survivors of the holocaust, even though they function fairly well, have problems compatible with the diagnosis of pseudoneurotic schizophrenia. That is, their neurotic symptoms represent a defense against a more profound and threatening regression. The other point is that in such patients, we

see emotional disturbances related to the most primitive levels of libidinal development—oral, narcissistic, or to use other terminologies, preobject phase or schizoid or paranoid positions. It is not my intention to confuse the issue by various terminologies, but merely to establish that no matter what the conceptual or theoretical framework of the psychiatrist, one has to recognize that the experiences of the persecutions have produced damages on a most profound and basic level.

All the cases beg the question of the interrelation of the patients' neurotic conflicts with the effects of the persecutions. The third case in particular shows a strong homosexual predisposition prior to the persecutions, as a result of the disturbed relationship in the family and the homosexual seduction by the brother. What can we observe as the shift in the nature of the problems as a result of the holocaust? The development upon which the patient dwells in his treatment is that of the death of his brother. In his obsessions, his dreams, his fears of his wife and therapist, there is a constant fear of the return of the threatening, vengeful, murderous ghost of his brother. The brother's death also symbolized the father's and even mother's death, and the destruction of the entire community. Thus the change caused by the persecution can be conceptualized as the loss of his ability to utilize the homosexual relation as a sustaining one, and its becoming destructive and threatening. In other words, the world-destruction events of the ghetto and concentration camp made it impossible for him to contain his aggression by a passive position. One can see how he identifies his brother with the Nazi aggressor, especially in the "bombing and execution dream." He is driven to handling his aggression by projecting it onto his brother, father, wife, therapist, and government. These defenses, however, were not successful, and the aggressive impulse to kill his wife and child broke through. The homosexual threat and paranoid problem have become unmanageable for him because of the reality of the extreme destructiveness in his life. One can hardly expect a more direct expression of the reason a paranoid individual so fears a homosexual attack than that expressed in this patient's dream, in which in succeeding to defend himself, he shoots off the tail of his brother's airplane. Thus, castration is equated to killing his brother, for which he blames himself, but which he has to do in "self-defense." In his regression and magical thinking, he expects the ghost of the dead

to come back and avenge itself on him. Insofar as he experiences the penis as the organ of destruction, and since he makes poor discriminations among the various objects in his life—all being narcissistically determined—he panics and wants to kill his wife when he sees her oversized clitoris.

Besides the problem of aggression which we would naturally expect in survivors of a genocidal attack, we have to consider how these problems become tied up with previous conflicts and defenses, particularly with the degree of resulting regression and damage.

The last patient's reality testing was so impaired that he experienced his wife's leaving him as the fulfillment of his death wish for her and his child. His problem with "the ghosts" of his lost objects is a struggle between restitutive, destructive, and self-punitive impulses. His choice of a mate was an acting out of all of these.

The generalization that can be made here is probably applicable to a variety of people damaged by extreme destruction. We are faced with a therapeutic dilemma not unlike that posed by schizophrenic, manic-depressive, and other severely disturbed patients. Their disturbances are so severe that modification of their problems may be effected only by very intensive and extremely long-term treatment. Such treatment would likely produce regression of such proportions that it would have to be done in a hospital. This would be especially necessary since the transference would at some point cause these patients to experience the therapist as extremely destructive, and either the need to provoke the therapist to assault or rejection, or the patient's assault upon the therapist or himself has to be expected.

Insofar as we avoid getting involved in such intensive and extremely difficult attempts to reconstruct the patient's personality, we can only accomplish very limited objectives in short-term therapy. We must recognize that by not removing their difficulties, we must limit ourselves to helping the patients live with them. We must also realize that the patients' symptoms are defensive in nature, and that when deprived of these defenses either by events of their lives or an overenthusiastic therapist, they are likely to develop more severe problems. This is the reason why we must be especially watchful of that kind of countertransference which may lead to "therapeutic enthusiasm."

In this connection, one special problem needs to be emphasized in the establishment of a therapeutic relationship. All of the

described patients had one common defense: avoidance of involvement in a personal relationship. Two out of three became much worse upon trying to stabilize their lives through marriage. One common problem in the survivors of the holocaust is a profound fear of getting to love someone. Having lost most, if not all, of their early love objects, they now fear that to love anyone means to lose them and go through the pain all over again. Since they have not been able to work through their losses (Meerloo, this volume), such a situation threatens overwhelming depression.

It thus follows that they are threatened by the possibility of an intimate relationship. They may try to ward it off by rejecting the offer of help, and by displaying aggression against the therapist. Such aggression is defensive in nature, and the more intense, the greater the yearning to reestablish libidinal object ties. It behooves one to appreciate that many an aggressive act or statement may also represent a testing of the therapist, even a symbolic gift or seduction. When one is successful in overcoming the patient's initial fear and aggression, he takes on a personal responsibility—for thereafter, abandonment of the patient may destroy him.

THE ROLE OF "MISSED ADOLESCENCE" IN THE ETIOLOGY OF THE CONCENTRATION-CAMP SURVIVOR SYNDROME

BRUCE L. DANTO, M.D.:

Much has been written since World War II regarding the psychological plight of the countless thousands of victims of concentration-camp living. Almost universally, emphasis has been placed on the horrible circumstances of their losses and the sadomasochistic experiences of the victims themselves. Perhaps it has taken those of us interested in this type of syndrome as long a time as has transpired to adjust our searching lines of inquiry beyond the time offered by history to work through our own reactions of utter horror. Perhaps there has been a need to deny that man could treat his own fellows in such a way within a framework that goes beyond that of a "safe phantasy."

In this paper, attention will be focused on one aspect of the syndrome alone, namely, the role played by "missed" or distorted

adolescence as it related to what has been observed in people suffering from the survivor syndrome. Most of the evidence used to broaden the base of discussion consists of the author's observations of such a victim who has been in intensive psychotherapy for several months. Additional information was abstracted from two case histories made available by Dr. Krystal.

Blos (1963) has stated that it is essential in early adolescence and adolescence proper that the individual renounce sexual ties to incestuous or primary love objects.

These phases, then, are concerned essentially with object relinquishment and object finding, and these processes reverberate in the ego to produce cathectic shifts which influence both the existing object representations and self-representation. During early adolescence and adolescence proper the drive turns toward genitality, the libidinous objects change from the preoedipal and oedipal to the non-incestuous, heterosexual objects. The ego safeguards its integrity through defensive operations; some of these are ego restricting and require counter-cathetic energy for their maintenance, while others prove to be adaptive and to allow aim-inhibited (sublimatory) drive discharge; these become the permanent regulators of self esteem [p. 75].

In the interphase between object relinquishing and object finding, the adolescent seeks temporary refuge in narcissism. The latter ego state of adolescence is one filled with various implications with respect to the survivor syndrome. Such implications concern the possible fate of the adolescent ego state taking a direction toward masochistic gratification, or toward seeking despair, which is expressed in weeping, suffering, or self-reproach. In the latter circumstances, according to Helene Deutsch (1944), these "narcissitic gratifications through suffering usually yield to moods of depression connected with feelings of inferiority, and may crystallize in a real depression that can lead further to a severe adolescent neurosis."

This period of transient narcissistic hypercathexis of the self-representation is brought to termination by object finding and resolution of bisexual and homosexual conflicts. If this struggle is resolved successfully, conflicts about activity and passivity are smoothed out and each sex adopts his or her specific sexual identity and surrenders to the opposite sex that bisexual quality which appears alien to the ego-ideal.

Of prime importance in general and more in particular to the area of interest in this paper are the numerous observations of clinicians about the need of the adolescent to deal with his ambivalent feelings and conflicts. Ambivalent feelings and phantasies frequently involve murderous wishes. The resolution and successful repression of such conflicts is materially aided by the fact that the objects of such feelings are living and present and this offers a necessary reassurance as well as basis for reality testing. In her discussion of pathological situations involving conflicts of ambivalent feeling, B. Bornstein (1949) wrote: "The presence of the ambivalently loved person prevents the phobic from being overwhelmed by his forbidden impulses and assures him that his aggressive intentions have not come true."

K. R. Eissler (1958) wrote:

Adolescence appears to afford the individual a second chance; it is a kind of lease permitting revision of the solution found during latency which had been formed in direct reaction to the oedipal conflict. . . . Regressive features are certain to appear, but I prefer to emphasize the release of forces that were bound in the structure and the ensuing reorganization through new identifications and the cathexis of new objects [p. 250].

Although highly condensed here, the above highlights of conflicts to be resolved and ego shifts should provide the background of a search for the effects of concentration-camp living on the developmental process of adolescence for those individuals who were entering or were already entrenched at that level at the time of their experiences.

No attempt is being made here to minimize the effects of the massive trauma itself. Rather, it is postulated that much of an individual's reaction to that trauma has roots independent of the trauma, and can mingle with or become associated with the events of later developmental experience. Sigmund Freud (1926) wrote:

In view of all that we know about the structure of the comparatively simple neuroses of everyday life, it would seem highly improbable that a neurosis could come into being merely because of the objective presence of danger, without any participation of the deeper levels of the mental apparatus. . . [p. 129]. In some cases, realistic and neurotic

anxiety are mingled. Danger is known but anxiety in relation to it is excessive or "over-great," greater than seems appropriate. . . [p. 166]. The surplus of anxiety reveals the extent of the neurotic element and upon analysis one can see where unknown instinctual danger has become attached to a known one. I have no intention of asserting that every determinant of anxiety completely invalidates the preceding one. It is true that, as life development of the ego goes on, the earlier danger situations tend to lose their force and to be set aside, so that we might say that each period of an individual's life has its appropriate determinant of anxiety. . . [p. 141-142]. Nevertheless, all these danger-situations and determinants of anxiety can persist side by side and cause the ego to react to them with anxiety at a period later than the appropriate one, or again, several of them can come into operation at the same time [p. 142].

Established, thus far, at least from a theoretical position, is the idea that a concentration-camp experience could complicate an already difficult phase of development. At the same time, one could respond to any type of trauma with anxiety, the determinants of which could not be completely divorced from earlier traumatic developmental experiences.

Clinical Material

Social histories and diary material of people studied within the historical period with which we are concerned reveal many dramatic stories. Perhaps one of the most poignant illustrations of the emotional impact of this type of experience can be seen in the diary of a boy, David Rubinowicz (1960). At the age of 12 he entered a concentration camp with his family and it was there that all of them were exterminated. The passage from his diary which is about to follow is chosen to assist in laying down the foundation for discussion of the problem area as outlined in the introduction.

My uncle came to collect Daddy's warm cap but he wasn't in time to pass it to him. I started shouting very loud when the trucks were near and shouted out "Where are you Daddy? Let me see you once more" and I saw him on the last platform. He was all in tears and I followed him with my eyes until he disappeared around the corner and then I burst out crying and I felt how much I loved him and he loved me.

Twenty-five days later, the diary ended as did David's life.

The above pathos was almost a way of life for many of the victims but, in contrast to the boy, their memories of last images of their loved ones linger on, like haunting ghosts. Had David survived his family, he too would have suffered an almost impossible task of mourning his loss of family. How, in this context, would he or any of these adolescent victims been able to break ties with incestuous objects in order to achieve one of the stated goals of adolescence? From this illustration, it does not seem untenable to assume that the concentration-camp experience provided a closed exit to one of the most important necessities of adolescence, one adding to the massive trauma of torture, fear of death, and both physical and emotional deprivation.

Case 1

Some months ago, a 35-year-old man was referred to me for evaluation and treatment of sexual impotence associated with premature ejaculation.

He was born in a small village in Poland, one already providing the pain of anti-Semitism from his earliest days of recollection. Orthodox Jewish by religion, he received his education at a parochial school. His parents owned a general store and he and his siblings worked there frequently. His developmental history is replete with material showing passivity in his relationships to authority figures. Phantasies and dreams were filled with manifest stories of being bitten by animals, attacked by anti-Semitic farmers with pitchforks, and seeing his mother stabbed in the back by knife-wielding robbers. His early sex-play activity had centered around a "doctor game," with girls, one consisting of having the girl lie down on the floor of a wagon and placing moistened pieces of cotton on the superior, ventral surface of her labia. Other sexual activities centered around voyeuristic pleasures derived from secretly watching his female teacher sitting on the toilet.

At home, he and his family shared the same upstairs room, and his dreams and associations to them show a clear recall of primal scene activity, with reactions on his part that involved sexual phantasies toward his mother and castration anxiety involving his father. Conflicts in the latter areas were present in his relationships with both boys and girls, and he showed much inhibition in seeking out sexual information about girls. In the latter regard, he was teased by his boy peers who considered him shy and "scared." While working in his father's store he would feel tortured by sexual excitement and by his wish to look up the dresses of the girls and women whom he would fit for boots.

Six months prior to the outbreak of war between Poland and Germany, his parents went to another country to investigate the possibility of settling there and avoiding the anticipated holocaust. Accompanying them were two brothers of the patient. Remaining at home with his aunt was the patient plus his two younger sisters and two-year younger brother. After Germany's invasion of Poland, he and his siblings, aunt, and a 19-year-old cousin hid out in a basement. Four days before he was discovered in hiding, the patient became preoccupied with sexual intercourse phantasies toward his cousin, and once he even reached out to touch her leg. She moved away from him and he was crest-fallen. He felt that since the future was so clouded with uncertainty, this was the time to be sexually assertive because many of his teenage peers were having intercourse "to have a taste of life before it all ends." Later, after she had left to rejoin her family in the Warsaw Ghetto and perished, he felt guilty about not being more sexually assertive as "she would have stayed with us and might have lived."

At the age of 14 years, he was forced to enter a concentration camp where he survived beatings, scenes of death, and uncertainty about the members of his family. He was assigned to a farm settlement and was released during the protective cover of night by a friendly gentile and told that his two sisters and aunt had been killed in a camp. He decided that his chances of passing as a Polish gentile were good as "I had a gentile face, but because my brother didn't he therefore had to hide for the rest of the war in that basement cellar."

The patient joined a forced-work group and was sent deep into Eastern Poland to work in one of the forests. While there, he fared well, completely repressed sexual activities, and avoided any masturbatory or homosexual gratification. In fact, prior to this time there was no history of masturbation. Intermittently, feelings of humiliation overcame him as he was stripped to the waist in front of civilian women and left in the room for several hours while his clothes were being deloused.

Following liberation by the Russians, he was transported to Russia, where he remained until the end of the war. While there, he attempted to become sexually involved with a female Russian soldier, but once he had an erection he lost it "because I was afraid she would discover I was Jewish."

At the war's end, he found his way back to resettlement camps in Germany, made money by selling items in the black market, and again found himself completely inhibited sexually. Others were unleashing a backlog of sexual feelings, and marriages and prostitution flourished. Conspicuous among the few who avoided the camp parties was the patient. However, his mother wrote of her wish for him to marry as it would enhance his

chances of surviving and migrating to their adopted country. As in the past, he obediently followed her advice and married one of the first women recommended by the marriage broker. On his wedding night he touched his wife's vagina with his hand and immediately had an ejaculation, without having penetrated her. The next day served as the beginning of a pattern which was to follow for several years: medical treatment via testosterone injection to cure his sexual impotence and premature ejaculation. They came to this country in 1949, one year after their marriage, and settled with relatives of his wife. He obtained employment as a salesman for a department store and has worked there without difficulty or change of jobs. He has experienced many sexual phantasies about women customers who buy from him. He always sees himself as a Don Juan with them, but his symptoms persist with his wife.

His sexual problems were so fixed that they were unable to have children in the early years of their marriage. They both underwent fertility studies and it was in regard to this that the patient stated that he attempted to masturbate for the first time. However, he was entirely unsuccessful. His wife managed to become pregnant in spite of their problems because he had occasional success, as is the case now, regarding orgasm immediately following penetration. Psychiatric treatment was recommended in 1950, but he did not seek it out until he learned English well enough and his marriage had taken a stormy course toward arguments over money and his wife's feelings that he was not providing his family with as many advantages as their friends and her relatives.

In psychotherapy he has shown resistance to establishing transference and free association, isolates himself against feelings, presents his therapist with numerous dreams—like the bearer of gifts—and has expressed some somatic complaints such as headaches, chest pains, tachycardia, and insomnia. Some progress has been noted since analysis of his resistance has been attempted. Other comments about his treatment material will be offered in the discussion section, but limitation of space in this paper prohibits presentation of more than two of the many rich dreams and associations he has offered for analysis.

Following the death of a relative, he had two dreams which contained rescue phantasies concerning his two sisters, and which also displayed features of survival guilt. Additionally, some delayed mourning was evident in relation to the dreams. Dream No. 1 concerned standing at the ground opening of a cellar, peering into the opening which was like looking from the top of an Egyptian pyramid down toward the broad base. Opposite was a mother cow which had given birth to two calves, both of whom had fallen into the cellar. He could see them far down in the cellar, resting on hay. He felt they were injured and wanted to jump

in to help them but was afraid the mother cow would bite him. Nonetheless, he jumped and slid down the hay while falling. Dream No. 2 concerned seeing himself in a row of people, all of whom were lying on the ground at night. His row was one of many successive rows. Five men with flashlights came along and awakened each person to check his identity. Each one turned out to have the face of someone the patient knew had been killed in the camps. The man next to him was covered with flour (he associated to ashes from the crematorium) and explained that he hadn't died. Rather, it had taken him all these years to dig his way out of the mountain of flour. He asked about the patient's oldest sister, and the patient answered that she too had survived but had recently disappeared. The dreamer then awoke.

Vignettes from two other cases are offered to serve as illustrations of trauma occurring during adolescence causing pathogenic adjustments during this developmental phase.

Case 2

A 12-year-old boy, son of a banker from Poland, was sent to one of the extermination camps with his family after all their property had been confiscated by the Germans. In a separation line, he was assigned to a work group while he saw his father and brother taken out and shot to death by the Gestapo. His mother and a brother were sent to another camp and survived the camp experience. They joined the patient after the war and subsequent to his arrival to this country when he was 16 years of age. In the interim, before the end of the war, he was marched from one camp to another, forced to sleep among cadavers, and had some toes amputated by a fellow inmate with a knife, and suffered a beating from another inmate in lieu of anesthetics. He had developed gangrene of the toes as a result of frostbite.

Following his arrival here he entered the army but was hospitalized for treatment of pulmonary tuberculosis. He has managed to obtain employment, brags of supporting his mother and brother, approaches life with intellectualized explanations and insights and is completely submerged by the effects of the concentration-camp syndrome as outlined earlier. He deals with ambivalent feeling in his object relationships by displaying passivity and ritualistic overconcern toward his children and surviving family members. He has been completely unable to feel free to compete with his highly successful brother or father in terms of his accomplishments in banking.

Case 3

The last vignette concerns a woman who was born in Czechoslovakia and was 13 years of age at the time of her camp experience. She alone was chosen to survive the selection line, and her parents and siblings were exterminated. At 14 years of age, a group of S.S. officers were aroused by her physical development and beauty. She was quickly removed from the group of female workers, who were regularly beaten, and was sent to an officer's quarters where she was raped by a band of drunk officers until she became unconscious and lost track of the count of assaults during the night. Following her recovery, she was regularly picked for similar parties, to which she grew to react as an automaton. At the time of liberation, she was a worker at an ammunition factory and was found wandering around the streets like an emaciated walking corpse. An uncle survivor joined her in her move to England, where she began psychiatric treatment. Subsequently, she arrived here and has continued to suffer from survivor guilt and the somatic symptoms of the syndrome. She displays outbursts of temper toward her husband and two children, after which she sinks into remorse. Her frigidity adds to her complete feeling of failure as a wife. Her marriage involved the choice of a man who was not from the camp experience, one who could assure her of protection against exposure of her traumatic indignities. Any and all who attempt to question her about her past and try to help her psychiatrically are met with expressions of resentment and defensive hostility.

DISCUSSION

Krystal and Niederland (1964) have observed that the most disturbed of the camp survivors can be found in two groups: (1) those who were persecuted during their adolescence; and (2) those who were subjected to sexual assaults. The clinical material presented in this paper should offer some evidence, on a small scale, of the validity of such observations.

Prominent among the ego defenses utilized by people who have been studied in relationship to their concentration-camp experiences are those of isolation, reaction formation, and undoing. Associated with these defenses are character traits like parsimony, orderliness, and masochism. These structural factors have been classically understood as having their roots and etiology in the anal phase of libidinal development.

As stated in the introduction, one of the most important needs to be met by the child in adolescence is his attempt to master oedipal conflicts and to break ties with oedipal and preoedipal objects. How could such goals be achieved in light of his forced regression to anal-retentive object-holding levels of dealing with the separation from parents by either transfer or death? It was as though, for so many of the victims, the camp stress forced a regression from the oedipal level of libidinal development to an anal-retentive and sadistic one. The latter regression was also brought about by the normal processes of mourning itself, and in this respect one can see where the victims suffered tremendous impairment of self-esteem, as reflected by survival guilt. The overall result was an inhibition or arrest of further growth and development in terms of what would have followed adolescence ordinarily.

In the case of the man who had worked in the forced forest-crew labor battalion, one had an opportunity to see where he had been rooted in a passive-type relation to his parents prior to the camp experience and had character traits involving ties to anal libidinal development and early phallic (urethral) conflicts. Thus, there were preoedipal overtones to the genesis of his neurosis and it is therefore understandable why he could no more enjoy masturbation than he could succeed in masculine striving, even in marriage. In this connection, Bloss (1963) has commented:

Total absence of masturbation during adolescence indicates an incapacity to deal with the prepubertal sexual drives. Furthermore, it indicates that infantile masturbation has been repressed to such a degree that the necessary alignment of pregenital drives with genital sexuality cannot be accomplished. Consequently, cases of total abstinence represent an arrest in psychosexual development which in itself is pathogenic.

Added to the conflicts with which this patient would have ordinarily had to struggle are the horrors of his war experiences which favored passivity as a character trait and survival technique. Mobility to suppress aggression negated survival. This quality, which was a definite type of survival trait, was well reflected in the other clinical examples and when considered along with masochistic traits, was seen in 88 per cent of the group studied by Krystal and Niederland (1968).

Dr. E. Sterba (1968) made direct observations on many adolescents following their placement in foster homes subsequent to their arrival to this country. Once they felt safe with their foster parents, they vented the fullest extent of their aggression on the substitute parents; and many could not permit themselves to establish object relations to such substitutes as they felt it would be an expression of disloyalty to their own parents, who were lost or buried somewhere in Europe.

Other expressions of their struggles, aside from the central case presented, concern attempts to reconstruct lost families through marriage and producing children, in addition to an almost complete denial of "fun," and an inability to display affect in marriage out of fear of disloyalty to the deceased members of their families (Krystal and Niederland, 1968).

For the patient whose parents actually did survive, and who live in another country, there is a struggle with intense rage toward them because of their desertion of him at a time of need, and resentment about their preference to save the two children they did in fact take with them. However, he attempted to deny his anger and inhibited any aggression toward them, even to the point of following his mother's advice about getting married. Since he has entered treatment, some of these angry feelings have come out and he has written some rather angry letters to his parents. As a consequence, some of the arguments he had had with his wife have eased up.

Krystal and Niederland (1968), as well as others interested in these people, have experienced and described certain difficulties associated with the attempts to treat them by means of psychoanalytically oriented psychotherapy.

The first patient presented by the author in this paper demonstrates some of the specific problems in the psychotherapy with survivors of Nazi persecution. Like countless others who shared similar or worse times during their adolescence, his regression was not fantasied; it was real and in keeping with the style of camp society and hardship. The aggressive feelings were more intense and in reaction to abuse and attack from real aggressors. Thus, the need to defend himself against such aggression by way of reaction-formation and isolation was so intense that the transference threatens his defenses. He has related to his therapist in the same way he has regarded all authority figures, and he reacts by using an almost impenetrable armor of passivity. His anal-type defenses present transference resist-

ance almost beyond modification. The fear of the magical powers of his aggressive wishes is supported in the fact that murderous fantasies toward an ambivalently loved parent seemed to have come true. Adolescent survivors of Nazi persecution could not use the presence of their parents for reassurance against the fear of their destructive wishes. The resulting guilt feelings as seen in their survival guilt make the therapeutic task of exploring these areas of feelings very difficult because of their need to defend against exposure of guilt. Their masochistic adjustment has become too important for them as a way of life and perspective.

DISCUSSION

DR. E. STERBA:

When we survey the problems of survivors of concentration camps in relation to distorted or missed adolescence, we can discriminate two groups: there are first those children who were born in concentration camps or were brought to concentration camps when they were very small, grew up there without mothers, and then were rescued and shipped to other countries around age five or six; the second group comprises those youngsters who were taken to concentration camps at the onset of or during puberty.

One might expect that with children who have spent their infancy and earliest childhood in a situation where they were exposed to such traumatic separations and object-changes, combined with the traumatizations which lead to the survivor syndrome, it is not possible to evaluate any phase of their development correctly because we have no possibility of comparing their experiences with the ones of any other type of disturbed childhood.

My experiences with displaced children refer exclusively to those who had spent infancy and childhood in concentration camps and were brought here between the ages of 12 and 20.

I have no experience with any youngster sent to concentration camp at the beginning of or during early puberty. The case which Dr. Danto presented is a 35-year-old man referred to psychotherapy because of impotence and premature ejaculation. He was sent to a concentration camp at the age of 14, where he was exposed to the hard-

ships of forced labor, after which he went to Russia, and finally came to a resettlement camp in Germany after the war. He was married when he came to this country and undertook treatment after he had mastered English. This patient's developmental history provides us with enough material to understand his passivity at the age of 14. He certainly had reached the stage of object constancy, to use Anna Freud's term. But from the material, we obtain no indication that he ever completed the phallic oedipal phase, and no indications of what Anna Freud calls prelude to adolescent revolt and adolescent struggle. That he married at the advice of his mother shows his lasting dependency on her, which certainly contributes greatly to his sexual difficulty.

I think we can rightly assume that the patient's passivity would have interfered considerably with his reaching a normal preadolescence and adolescence. It is questionable to what extent he would have been able to loosen his infantile ties to his mother even had he not been exposed to the concentration camp and its horrifying traumatization.

Edith Ludowyk Gyomroi published in *The Psychoanalytic Study of the Child*, volume XVIII, the analysis of a 17-year-old girl, Elizabeth. This girl and her sister were sent to the concentration camp at a very early age. At the age of four, she was brought to England where she was boarded in a specially organized children's home, supervised personally by Anna Freud, where everything was done to provide the children with homelike environment and possibility for normal development. Elizabeth seemed to settle down normally at first, but as she entered latency she changed; she became naughty and was unable to learn. Her difficulties seemed related to the missing mother-relationship, although she was at the same time deeply attached to her housemother. At the beginning of adolescence, her problems increased greatly. There was no evidence of striving for independence; her dependency now became excessive. At the age of 17, she expressed the wish to be analyzed. This was only partly her own independent desire for improvement, insofar as it was also an expression of her identification with some of the other children of the home who had entered analysis.

The analysis helped her to make up the missed developmental stages; her ego was reconstructed to a degree where she was able to achieve a relatively normal mature independence.

I can add here my own experience with a foster child. Vicky was found without parents in a concentration camp. At the age of four or five he was brought to England and entered the same home as Elizabeth. He was one of the first children of the Foster Parents Plan. Anna Freud selected him for me as my foster child. His developmental history was particularly traumatic with regard to his mother-relationship. When brought to the home, he first adjusted to the new environment easily and without apparent difficulties. He became very attached to Miss Goldberger, the housemother at the children's home. After a few years, when he spoke English fluently (his first language seemed to have been German or Yiddish), the Red Cross notified the housemother that Vicky's mother had been found and that she was taking the necessary steps toward reclamation. The boy was doing very well at that time and had entered the latency period. Nonetheless he had to be informed that he was going to be returned to his mother, and he had to relearn German because the mother was of Austrian origin. When the complicated plans for his return to his mother were almost completed, the mother had disappeared again. So Vicky had to stay at the children's home in England. As was to be expected, he became a problem at this point. He had been a well-adjusted, uncomplicated, easily directed, happy boy in latency. Now he became aggressive, was constantly dissatisfied, did poorly at school, and even began to steal things from the other children. He proved very difficult to handle. We, the foster parents, had been in contact with Vicky, having visited with him at his home, and having taken him out with us in London to see the Tower and other sights. When he was 14, we invited him to spend the summer vacation with us in our summer home in Vermont, in order to give him as much as possible the experience of family life, and also to ascertain whether his problems were serious enough to require analysis. Vicky's adjustment in his first real family environment was interesting. He was brought to this country by his housemother. It was easy for him to transfer his attachment from Miss Goldberger, the housemother, to myself, and from the first moment, he regarded my younger daughter, four years his senior, as his sister. He had ample opportunity for normal adolescent behavior. There were a few adolescents quite uninhibited in their thrusts for independence, but Vicky was only critical of their attempts, and it seemed that their behavior increased his need for dependency on a mother person.

"But you will have time for me?" he said many times a day, although I devoted enough time to him, while all the other adolescents who stayed with us enjoyed their freedom. He more or less ignored the father person; the only masculine relationship he maintained consisted of playing cards with my houseman. During his stay with us, there were no educational problems; he did not steal; he was a very pleasant member of the family, and he was not the only one who felt sad when he returned to England at the end of the vacation. The stay with our family obviously had been very therapeutic. Vicky kept in close contact after his return to England; we frequently exchanged letters. His behavior was markedly improved, and he did much better at school.

When Vicky was 17, the mother suddenly reappeared and once again claimed her son through the Red Cross. In the meantime, she had had two children who appeared to be illegitimate. However, she had recently married an American soldier in Germany, whom she had met as a waitress. The family established residence in California. This time, the mother had been sufficiently prepared by social workers on how to approach her son. I was to see him on his trip to California to prepare him for his new life. He was fearful but also curious at the prospect of meeting his real mother. This summarized his feelings: "You won't be angry if I don't write 'mother' to you anymore, but I can still write, can't I?" He was able to adjust to the new life situation; he had all the freedom he wanted; the stepfather turned out to be a passive, withdrawn invalid who never interfered, and Vicky got along with him very nicely. He lived with the family for a while, then went into the American Army, where he enjoyed his position as airplane mechanic. Recently, he married and seems happy. We still are in contact via letters.

Vicky was the simplest and most uncomplicated case of concentration-camp survivors I have observed. He was able to deal with the taxing experiences of finding his mother, losing her again, and regaining her a second time, together with a whole new family. The relation to his mother was the center of his emotional life. What offset the traumatic events of his early life was that he was fortunate in finding a marvelous, most understanding mother substitute in Miss Goldberger, and a distant and idealized mother figure in myself, a figure which remained not only in fantasy, but took on reality through personal contact, sporadic though it was. Finally, he re-

gained his real mother and was taken into her family, which also became his own.

A more refined study of Vicky's development and the vicissitudes of his relationships could only be made in an analysis, for which there seemed to have been no therapeutic need.

I hope that it is as comforting to you as it is to me to know that such a fortunate outcome of the development of a child so severely victimized as concentration-camp children are, is possible. But we learn little from such a fortunate case; for deeper psychological studies, we have to rely on the analytic studies of less happy endings of victims of Nazi outrages.

MAX WARREN, M.D.:

Thank you very much, Dr. Sterba, for the personal vignette of your experience with a survivor, and also for the opportunity to contrast the situation you describe in relation to this boy with the one that Dr. Danto is treating now.

I am reminded, in your description of the substitute mother, how fortunate this child was, especially against the prevailing background of postwar Europe when many of these children were not free to get immediate replacement, but were kept in these detention barracks for the same period, thereby adding to the traumatization. I am also reminded of how long it had taken—almost 20 years—for this interest in massive trauma to really receive any sustained attention and study.

QUESTION:

I have a question regarding these children who were either born in the concentration camp or brought there at a very early age. With such early separation, never knowing the mother, how do they develop the same problems of incest that other children do who actually knew a mother and then were separated?

DR. STERBA:

I don't think that we are able to ascertain correctly, in each case that developed, the same problem of incest, although there is always something that happens in a child's life that gives him the opportunity to develop oedipal complexes. However, it is my feeling that

we cannot ascertain how that development goes, because we have no possibility of comparing these developments of the children in the concentrtaion camps with any other developments which have taken place under such very unusual conditions.

DR. WANGH:

I should like to comment on this problem from the theoretical point of view. In a case which is reported in the *Psychoanalytic Study of the Child*, Anna Freud speaks of this little girl's attachment to an older boy and to an older girl. The point is that there is always somebody who will be representative of that which nature demands should be represented. Studies show that children at the age of six months to three years form attachments to siblings, as well as to their mothers. The children in concentration camps, especially Auschwitz, did form a very tight little clique and clung to each other. These children could not have survived at all had there not been some protection from the others among whom they lived. There have been descriptions of how they were hidden under the beds whenever the inspection came. Thus there were substitute parents who gave some love to these children, and therein lies the key to the development of the oedipal complex in these cases.

One might wonder what is a worse fate—to be born as a child in the concentration camp, or to be brought there as an adult? If we, from the outside, look at this environment, we can only say that it is a psychotic world into which this child has been born. However, it is the child's world, and it is a world organized in its fashion. The problem would only arise when the child is removed from its world.

Now, the case presented by Dr. Sterba was also brought into an organized world, a group home; something of the previous experience continued there. Such an arrangement was fortunate; an immediate assignment into a family group might have been traumatic. I would like to ask Dr. Sterba what she thinks about this. Some development takes place even in a psychotic world. These children are not in tune with an average environment; this only becomes evident when they are confronted with another environment. In Israel, youngsters who have been brought up in a kibbutz, in community halls, boys and girls brought up together through high school, when they enter industrial life somewhere outside the kibbutz, typically have a difficult time compared to the city children who are brought

up individually. But then, when they come to the army, they are the best adjusted soldiers. The previous environment has prepared them for the army style of life. It might be that we have something similar operating here.

The question of adolescence—if these children would have continued living in a concentration camp or concentration camplike structure, the difficulties which arose in later life may not have arisen. What our life particularly demands here is an active, positive adjustment, an area in which these people fail, falling back into the pattern which was once enforced. This previous pattern tends to continue, particularly whenever anxiety exists.

DR. STERBA:

I am quite in agreement with what Dr. Wanhg suggested. Of course, the environment these children were brought to in England, although one tried to make it homelike, was completely controlled. As Dr. Wanhg described it, it was a completely unnatural environment because there were so many children together—it was like a camp, although it was a much better life.

I would like to add a small detail here. The choice of the army was, I have to admit, my suggestion because I thought that my foster child would be best able to adjust if he got out of the family situation. Thus I advised him to go into the army because that was such a regulated camplike environment again, and I can say, although this was an assumption, that he is doing so well because he still is, in some ways, connected with the regimented way of life.

DR. WARREN:

That was an interesting commentary. I recall a young concentration-camp survivor who made out terribly after he came to this country. He claimed that the happiest moments of his life had been when he was in the army in Denver, holding the position of orderly in the company squadron, and he was the pet of the barrack. He described, as you mentioned, that he was perfectly well-adapted in this situation.

DR. DANTO:

In terms of group reaction, it is remarkable how easily the scapegoat becomes a pet. I would like to add some comments to these very interesting points that the other participants have raised.

In regard to the man whom I presented in my paper, it is interesting that recently material has come up in treatment regarding his feelings about being taken care of by the older men in the camp, his relationships, and how this is reflected in his feelings on the way in which the camp became protective toward the "musulman." It is interesting that, although he himself never took food or boots from the "musulman" in order to effect his own survival—which was a customary practice—while others would take boots and bread from the dying "musulman" and give it to him as well as to other children and themselves, he developed a protective feeling toward the "musulman." This was true of others, too, who would assist the "musulman" from the work detail back to the barrack, because if a guard saw that a man was so weak that he couldn't walk he would be taken out and shot.

Along with this protective feeling on his part, was a kind of compulsive ritual whereby he felt almost contaminated by having touched the "musulman" because he was afraid he would become like the latter through identification and hardship. To further avoid "contamination" he would have to wash his hands in snow or sand, depending on the climate. Now this in itself is interesting, particularly when regarding it against the culture and folklore of the small Polish town from which he came. That is, already implanted in his mind, before he got to the camp, were values, myths, and concepts of death which gave additional meaning to the kind of psychopathology that arose from camp living. In his culture, there was a fear of counting people, out of the belief in the "evil eye," and it was the custom in his school to count in negatives: not 1, not 2, not 3, etc.—this was a form of undoing.

If a youngster had a dream about someone dying, or an adult did for that matter, it was customary to run to the rabbi to find the meaning of the dream as one would approach an oracle. The rabbi would say: "It's good luck that you dreamt of your mother dying, because that means she is going to live to a ripe old age." If the patient had a dream, as he frequently does now, about death—involving the color white—this was interpreted to be a bad sign because it was equivalent to the color of the cloth used to wrap the dead. However, if one had a dream about the color black, and the patient frequently dreams of black blankets and things, this was a

good sign because it was opposite to white, which meant that a person would live to a long life.

I could go on with similar examples, but I think it is important to highlight some of these areas because it helps to explain how the impulse to help other prisoners would have been a form of undoing, which was prevented and punishable by death. This was one of the reasons why it was a dangerous thing to become emotionally attached to people, like the “musulman,” earmarked for death.

DR. WANGH:

I had an interview just three weeks ago with a girl who apparently was given away by her parents when they were sent to Bergen-Belsen, to a Polish couple who were also being sent to Bergen-Belsen, but who the parents knew would be better off than themselves. This Polish woman became very attached to the girl; as a matter of fact, she still writes to her. She now lives in Russia. The girl writes to her as “mother” and this woman writes back to her “daughter.” The circumstances surrounding this case were fortunate insofar as this girl was very ill at the end of the three-year Bergen-Belsen period, as a result of which the mother finally got her back, and the family was reunited. There is certainly a very warm object feeling here that I would suspect may not be the case in others who did not have such a constant mother available.

Interestingly, although once seriously ill this girl subsequently appeared to lead a charmed life. I would speculate that she had seen the worst—nothing more could happen to her. When she came to the United States, the family lived in a Negro neighborhood in which she was the only white girl. Apparently, she moved with great charm through this neighborhood, which was considered to be very dangerous, and was never harmed.¹ So, sometimes, out of great disasters, certain people can develop particularly fortunate traits.

MENDEL W. ETINGER, D.O.:

Usually we find that children who had been taken in by gentiles did experience a home with people who really loved children to begin with, and had a feeling of responsibility to protect them. These children made a very good adjustment for the simple reason that

¹ C.f. the “survivor hubris” of Lifton, Chapter VII.

they received so much love from the substitute parents. Furthermore, they were able to regard the substitute parents as their real parents, even though they could also accept the parents who did survive.

DR. DANTO:

Among the young people who were “adopted” by foster parents, we would expect responses that would be a little different, to my way of thinking, from those of the so-called cellar victims—the ones who hid out during the war, because it was a different kind of adjustment they had to make. If anything, in youngsters hidden for years in cellars and holes in the ground, we find object hunger; but at least in the camps, regardless of all the ambivalent feelings, one sees where at least there were people who did care, there were people who prayed, there was group identity—all of which permitted some imitation and identification.

GLENN GALLOWAY, M.D.:

In state hospitals, we see people who have grown up in psychotic households or who spent much of their childhood in state hospitals, or experienced some great calamity like observing their entire family dead in front of them in an automobile accident, etc. There are many, I think, comparable everyday sort of exposures to these traumas. In the theory of ordinary psychotherapy, it is more or less based on a premise of a reasonably healthy family, where the child has certain conflicts which arise on a phantasy level, and which lead to the occurrence of certain fixations and repressions. The theory of treatment in such cases is to let the repressions receive emotional messages, through the patient-therapist interchange, that somehow offset the fixation, thereby allowing for reality testing and normal ego development. However, it seems to me that this is a model which is simply inapplicable to the kind of trauma we are discussing. Certainly, the realities of these traumas do provide a lot of primary-process distortion and can be handled in a neurotic fashion, but there is a genuine reality to be dealt with. The child is, if you will, programmed with reality. How are you going to undo that event? You can not. But what kind of theoretical structures do we have at our disposal to counterbalance normal but excessive learning which happens to be inappropriate according to the ordinary probability and expectations in living, but which for that person happened to

be correct and happened to make a greater than ordinary impression. It would appear that this is an entirely different model and we have to change our approach accordingly. I am just not sure how to make the shift, and I would like to hear what the panel has to say about this.

DR. WANGH:

I have some thoughts about this issue because I do think that, theoretically at least, we should consider these people as having grown up in a psychotic environment. Now, as to the question of reality testing: even if we refer to a psychotic environment, not all people who come out of a psychotic environment come out in the same way. For whatever the reason, some have a greater capacity for a sense of reality; some have a greater capacity for reality testing; some have a greater intelligence which allows them to ward off dangers intellectually much more effectively because they can organize their world perceptions. So, there are constantly individual differences, and I do not think there are blanket answers; each case will have to be treated individually in consideration of the single ego functions which are deficient, in relation to those differences. Anna Freud (1965) as well as Beres (1956) have stressed the fact that not all the ego functions are equally impaired in psychosis, so the problems and approach to them must vary. However, it is safe to presume that one must extend to such people parameters which one would not extend to a person normally grown up in what we call a purely "neurotogenic environment." The young boy about whom Dr. Sterba reported was not analyzed; rather there was a manipulated environment. This is the kind of thing one would have to do for a patient whose ego structure is too weak, before psychotherapy is possible.

DR. DANTO:

You were saying then that your preferred method of treatment, instead of analysis, would be to provide ego experience through manipulation?

DR. WANGH:

No, I am not saying that. I am saying that you might have to do this with a child or perhaps with a severely regressed adult. If you

send a psychotic patient to a hospital, you manipulate his environment. One should be ready for such intervention; one might have to say more to a patient who has a weak ego structure, a weak reality testing ability, than to another. You would go through the details of whatever it might be to a much greater degree—point out much more.

Dr. Danto remarked about the therapist's difficulties in the case he presented. I think there is a tendency to be impatient. Such a patient will take a very long time. One cannot really expect much of a change in defenses in eight months of psychotherapy. This is an unreasonable expectation in cases of premature ejaculations of any sort. It would probably take many years, years of building up trust. Where do we begin speaking of psychoanalysis? When we change defenses by establishing trust, we are already in analysis.

MILTON J. STEINHARDT, M.D.:

I would like to call attention to Dr. Galloway's comment about the fact that massive psychic trauma may exist in other situations, and of course we know it does. In the play "The Deputy" I found it very interesting that the first thing the commandant did was to ask one of the people that came in to be questioned to slap another man, somebody whom he respected. They presumably were all people who were Christians of Jewish descent. The point I am trying to make is that there was a dehumanizing—these people were subjected to such psychic trauma they became dehumanized.

I would also like to make the distinction with respect to massive trauma that some of us have experienced. For example, in landing on D-Day, which I did, I saw many bodies strewn all over; I saw ships flying in the air; I was under tremendous stress—but there is a difference. I was in a potentially traumatic situation, but I had a purpose. I felt that I was doing something; my morale was high. Of course I was afraid I would get shot at any moment; we were all aware of that. There was much happening that could overwhelm one, and had it lasted much longer I might not have been able to take it. The point is, that one is able to endure a certain amount of trauma, but the dehumanization of the camps was so humiliating, so purposeless, so psychotic (as you indicated) that the defenses had to be those of denial, isolation, and projection. This brings to mind an experience I had when I was in Brussels, Belgium during the war.

I met a young man who was dealing in the black market. I was friendly with him and asked him why he had to do that—couldn't he get a job? He asked me a question that I found difficult to answer, "Did you ever go without bread?" This was his way out. In other words, another one of his defenses was that his superego went haywire; he didn't care anymore; he had enough of it and he was going to do what he wanted to do regardless of the consequences.

BERNARD LEVINE, M.D.:

The individual who cannot pay the price of emotional attachment or involvement under circumstances of imprisonment and persecution has been mentioned. Unfortunately, this aspect of an individual's dread of involvement has been exploited in the past. In interviewing American prisoners-of-war, it was determined that if such a group of people were to be isolated, escape could be prevented with minimal guards.

The reluctance to form any contact, any emotional involvement with the next individual, was so great that the victims were unable to bring about even minimal organization, enough to effect any kind of social structure. Thus an infinite number of abuses could be undertaken without any resistance whatsoever. What is really involved is an individual who, regardless of the intrinsic purpose, is willing to pay the price of detachment for survival.

DR. WANGH:

I want to call to your attention a book by Eitinger (1964) in which the author inquired of people in Norway and in Israel, in a gentle way, why they survived. He informs us that he received many of what he considers to be fictional answers, because he says the main reason why people survived was chance—e.g., whether the transport arrived at a certain place or not. It had nothing to do with the survivors—it had to do with the train. Thus, in the main, it was chance which enabled survival. But, he indicated one point: that those who survived had some greater ability for object relationships and could sustain one another. If one were an isolate nobody was willing to offer sustenance. One could be taken away at any time, particularly at the slightest illness, so object attachment apparently did have some use.

You speak about purposelessness: we can turn it the other way around—the purposefulness with which the Nazis operated. For people who had burned Freud's books, they were extremely well-informed about superego structure and ego structure and how to demolish it piece by piece. This is what we observe: that since any adolescent can really be reduced to a very infantile state of living, the regaining of any responsible situation afterwards becomes traumatic in itself.

SOCIAL WORKER:

I think there has been a great deal of stress on the similarities between the trauma of the survivor of Nazi persecution and the trauma of other disaster experiences. My concern is that there is an over-amount of stress on the similarities and not sufficient stress on the many differences. I know that you want to study the similarities for future scientific purposes, but I think you should also recognize, or at least verbalize, that what these survivors of Nazi persecution went through will probably, hopefully, never be duplicated, and that we should understand in the study of people of other types of disasters just where the differences lie.

DR. WARREN:

I think some of those differences were brought out very clearly by Dr. Venzlaff (Chapter 5), e.g., the difference between the fantasy persecution and actual persecution carried out by the State against a select group of people, which is really a very critical distinction. And I think that in contrast to an individual trauma or disaster, as Dr. Lifton brought out with the Hiroshima experiences, this was an overwhelming single massive trauma which had later subsequent effects. I think you bring out a very good point about underscoring some of these differences. Perhaps some of us might wish to extend that concept.

DR. WANGH:

Your point is an important one. The environment was not just suddenly traumatic for one day or one week—it continued, and if we have any comparisons, we can only compare with what we know and not with something of which we have no imago. The comparison,

therefore, is with a situation in which the prisoners remained for a long time in a malevolent environment, as for instance in the case of a child who would live with a psychotic mother or a psychotic father.

DR. WARREN:

Did we get around to answering Dr. Galloway's comments on differences in approach? One question occurred to me. Many times in seeing a severely traumatized victim who presents with so many complaints, so much dissatisfaction, there is a temptation to make up to him in some way for what he has suffered. The question does arise as to what extent and in what way might one gratify some of these needs, and in what framework. I think what Dr. Steinhardt mentioned is very important: even if one wanted to do something to help, how difficult it is for these people to trust and accept. This poses a serious problem in therapy. I wonder if any of you would have any comments on this.

PARTICIPANT:

Although you can not undo anything, if the patient is neurotic there is the opportunity to promote additional normal growth. However, in the traumatized you have had an experience which was received in a reality not a phantasy of punishment—this was a reality event which is an ego, not an neurotic superego issue. It is a different kind of issue and this makes it very difficult to “work through.”

SOPHIE FENIG, M.S.W.:

You can not undo anything with a neurotic patient either. I'm not saying there are no differences in the experiences, but you can not undo either one. Thus, this is not where the dissimilarity is; the basic difference is that reality was so difficult that it is unrealistic to expect the therapist to say: “All right, your parents weren't so good, but this harmful experience was not ‘personal’.” You have to help patients accept the experience with a reservation. I'm working with a woman who has three handicapped children and a husband who is dying from a heart condition. She has asked me: “What can you do for me?” I can not make her children free of their problems and I don't really think her husband is going to live much longer—I am unable to change this reality—but I hope that I can do something

in helping her accept what happened and to realize that she didn't cause it, no matter what her phantasies are about how angry she has been and what her magic can do. I must make her see that she did not make her children handicapped and that she did not kill her husband. I can only help her to adjust to the existing realities. I think this is all one can do for anybody who has gone through any kind of tremendous trauma. As in the case of a Negro who has been tremendously discriminated against, one must help him accept reality while pointing out the various differences.

DR. DANTO:

Of crucial importance in working with these people, is dealing with the problem of mourning. This becomes a very rough task for the therapist, as was brought out very well by Dr. Niederland—you have to be prepared to mourn with these people. If they cannot give up an internalized object, in terms of our current concept of mourning and depression, and the loss of self-esteem that goes along with this, the patient remains ill. But the transference resistance is one in which the patient experiences the therapist as the murderous persecutor, so how can he bring himself to trust us enough to make treatment possible? In addition, the problems of countertransference are unique and very difficult when the patients experience us in this way.

DR. WANGH:

I think that basically we can only do what we have always done. We enlarge the ego's capacity to tolerate stress, loosening the connection between the phantasy of the wanted death and the reality of it. Very recently, Dr. Araico from Mexico presented a paper in which he described a woman who was apparently involved in a delayed mourning reaction or absent mourning reaction. During the analysis, there came a period of great crisis, and at that time he made himself available to her during one week, and sat with her for five hours on two evenings. It seemed to me that he fulfilled something which we know from normal mourning: namely, that during the time of mourning among Jews (sitting sheva), one comes to visit and sit with the mourners. One offers oneself for that period as a substitute object, in a sense. Under such traumatic circumstances then, there

might be some need for a greater interaction between the analyst, social worker, or other therapist, and the patient. In all these situations the difficulties lie with our own countertransference reactions. The process of mourning has all of the qualities under normal circumstances, phantasy-wise, for being a psychotic process. If one listens to someone who is mourning, listens to his dreams, suddenly much old material surfaces that wouldn't be there normally. In the face of tragedy, people sustain each other; they have ceremonies; Catholics hold big wakes. All this is intended to bolster ego functioning when it confronts the impulse to deny reality in the process of denying the loss of the object.

DR. GALLOWAY:

Then the answer is two-fold. We deal with the neurotic components—magical thinking, etc.—to try to get the neurotic component and consequences as well taken care of as possible, and by the more or less standard models of therapy. The second aspect is to be willing to participate more on a reality level, in addition to the psychotherapeutic level required.

Summary

DR. WARREN:

Dr. Bruce Danto presented the case of a boy who was in a concentration camp for a while, later lived in the forest, and came to see him as an adult. The problem which is presented is that of "missed adolescence." Dr. Danto spoke of some of the experiences that this man had undergone in the concentration camp and forest, and how these experiences affected his defensive patterns— isolation, undoing, magical thinking—while describing the difficulties presented in the psychotherapy. There was actual need for objects to be living and present in order to work through the adolescent development. In this particular case, the patient's parents and two brothers had migrated to another country and actually were not lost to the patient, a rather atypical situation in contrast to the massive traumatization where many survivors lost complete families. This case was interesting in this respect.

Dr. Editha Sterba, in her discussion, said there were two types of patients that she encountered in her experiences. One consisted of those born in concentration camps or shipped to concentration camps around the ages of five and six; the other was those who were taken to concentration camps at the onset of or during puberty. In the outcome, it would be rather different for both groups. She described an experience with a foster child who was given a very good hospital experience around the age of five, had an excellent mother substitute, and was later adopted by the service under the Foster Child Plan. This child was able to survive the experience of finding his mother, losing her, and finding her again. Dr. Sterba described how this boy came to this country to live with them—the family experience and the many positive results obtained from it. The case presentation did bring out one interesting thing: that this child had lived in community and camp situations during the formative years of his life. Consequently, his possibilities of adaptation were significantly better in camp situations, and one of the best situations encountered was army experience. He was much better prepared to live in the army when he came to this country subsequently than he was, to some extent, prepared to live in the everyday civilian life that would have been the case otherwise.

Some of the questions which arose during the discussion had to do with the comparison of the types of trauma. Attempts were made in some way to relate psychotic families or psychotic conditions with the massive trauma situation, and the point was made that while there are some similarities, there are some very significant differences also.

The question was also raised as to how psychotherapy could be altered in view of the massive trauma experience—in what ways the psychotherapy would have to be modified from the basic technique. The objective was assumed to be to help in undoing repressions and trying to cope with the primitive phantasy life, bringing it more in line with the reality principle.

It was also brought out that one can not undo a happening or an actual experience, but one can deal with the patient's view of the experience, his conceptualizations and attitudes about it. Furthermore, the therapist can be more available at those times of crisis which come up and which call for reactivation of mourning syndrome and similar experiences.

IX. Rehabilitation in Trauma following Illness, Physical Injury, and Massive Personality Damage

THE PSYCHOLOGICAL COMPLICATIONS OF CONVALESCENCE

H. KRystal, M.D. and T. A. PETTY, M.D.

A purely psychoanalytic study of convalescence presents special problems. In many analyses problems of convalescence appear, either as part of the anamnesis or reconstruction or as a development in the course of an analysis. The development of a serious illness and one which would result in a loss of a significant part of function of one's self would be so disturbing to the usual procedure of the analysis that, whereas the study of convalescence could proceed, the analysis could not. To approach, with psychoanalytic techniques, people who are already ill presents special problems related to the narcissistic withdrawal which accompanies illness (Dunbar, 1943; Krystal and Petty, 1961).

On the other hand, the variety of regressions which do take place in illness make possible the discovery by a trained observer of much telltale evidence of psychic processes previously discovered and described by psychoanalysis. For this reason, we will utilize material derived from psychoanalysis as well as direct observation of patients in the process of convalescence and rehabilitation at the McGregor Center. By combining the two approaches, we hope to piece together the finer aspects of convalescence and its distortion which lead to emotionally determined complications.

Before proceeding to discuss the complications of convalescence, it is necessary to define and differentiate the terms involved. First, let us distinguish the word illness from convalescence. The illness is

defined here as the original disturbance of normal function. In relation to infection, it would be the invasion of the body by a foreign organism. In relation to emotional problems, we would conceptualize the illness as the return of repressed impulses and their threat. Convalescence will be defined here as comprising all the reactions and processes leading to or attempting to restore normal function.

The arbitrary definitions used here have their shortcomings, for illness may be utilized defensively in other spheres of function (Bartemeier, 1951; Dorsey, 1955, 1947; Dunbar, 1943; Jelliffe, 1930; Sadler, 1954). Convalescence may be more disabling than the illness itself; for instance, in infection the inflammatory (defensive) response causes most of the disability.

In studying the psychological complications of convalescence, we became impressed with the fact that the very process responsible for recovery may become involved in its complications (Krystal and Petty, 1961). The process and outcome of convalescence are influenced by several factors such as the individual's character, the nature and severity of the illness, as well as the form of onset of the illness. In the present study, evidence presented itself that in many cases an important factor in determining the course and outcome of convalescence was the patient's psychic reality existing at the onset of the illness.

Where the life situations were particularly trying and difficult, they represented a strain upon the patient's normal defenses. F. Dunbar (1943) had attempted to correlate stressful situations and characterological predispositions with specific diagnostic entities. Such simple and direct etiological relations were not found in this study. In fact, the subject of possible relation between the life-stress and the clinical entities is so complex as to discourage even an attempt at discussion here. The topic of the present discussion will be the *effect* of the *premorbid stress* not as a possible etiological factor in the illness, but in relation to *convalescence*.

In the present study, evidence presented itself that the stress many a patient was under before the onset of the illness was one he was unable to escape or modify. The particular stress was a kind that involved the patient's basic needs, and often revived significant unconscious, infantile conflicts. Consequently, in such cases, the patient, prior to the onset of the illness, had to ward off an unconscious phantasy generated by the stress, but which involved, through

a libidinal regression, the quintessence of the patient's neurotic conflict and his characterological defenses. The unconscious phantasy, involving a wish for the fulfillment of some need, sometimes encompassed acting out that led directly to the onset of illness or traumatic accident.

Most of the material discussed here has been derived from psychoanalytic work, in which reconstruction establishes certain probable historical developments, sequences, and relations. The hypothesis of cause-and-effect, however, can never be proven—as one thing cannot prove another.

Similarly, the application of psychoanalytic insight to clinical data observed in an acute hospital case presents special problems. For instance, we may be able to observe evidence of preconscious phantasy acted out, dramatized in conversion symptoms, or reduced to affect expression only through a regression to somatization, and thereby have to reconstruct the effect of such phantasy upon the process of convalescence.

At times, when applying psychoanalytic interpretation to somatization or acting out, it is difficult to say whether such phantasy preceded the onset of the illness or whether it was produced after its onset, as a means of rationalizing the unconscious meanings of the potentially traumatic awareness, and only secondarily involved in the patient's transference objects. The following case history represents a situation in which the premorbid stress appeared to have had a causal relation to the illness, and persisted as a factor in the determination of the course of the patient's convalescence.

J.R., a middle-aged man, was admitted with fracture of the left tibia and fibula. The patient was walking across the road inside the factory premises. The very first thing he noticed was a pain in his leg. He fell. Between that time and the next day when he was told he had been hit by a truck, his *memory was very hazy*. The patient never recalled the actual circumstances of his getting in front of the truck.

The patient had been divorced for many years. He left his wife and children when he felt the wife "liked someone else better." He said that upon discovering this state of affairs "something cut between us" and since these happenings he'd been "half a man."

For the past 20 years, the patient lived in a flat with his brother; because of his brother's chronic illness the patient was bringing in most of the money, working as a very steady shop laborer. Three weeks before

the accident, the patient's brother was advised to leave Detroit and to go to a chronic-type hospital for prolonged treatment. The patient objected to the separation. Gradually he became depressed. He had an accident at the shop, cutting off part of his left index finger. This was healing well. The patient begged to take the day off—and to go to the clinic. His supervisor, however, insisted that he come to work. The patient came to work several hours late—and was hit inside the plant on his way to work.

At the hospital the patient at first was cheerful and cooperative. His brother had decided not to go away because of the patient's condition. A few weeks later, however, the brother decided to go ahead with his plans and leave town.

Subsequent to the brother's decision, the patient maintained his pleasant demeanor, with his rather fixed smile, and was just as friendly as at the onset. It was noted, however, that he became insomniac and anorectic; he lost 15 pounds in two weeks. When his state was discussed with him, he denied that he was depressed because of his brother's going away, but his appetite and sleep improved after the interpretation. He expressed the feeling that if the brother left he might "have to get married."

In the above description, there is evidence of a serious stress associated with yearning for passive fulfillment, which would not be experienced directly. What happens to such yearnings with the onset of an illness?

At the present time, the following observations can be made pertaining to this point: while the onset of the illness or traumatic injury often represents a breakthrough of an unconscious ego-alien impulse, the new situation may gain ego complicity providing the originally dangerous idea remains repressed.¹ Freud and Ferenczi pointed out that physical illness may lead to certain mental illnesses. Freud (1955a), for instance, pointed out in the case of the "Wolfman" that the patient's gonorrhea was the precipitant of his neurosis. Ferenczi (1953) was so impressed with the role of physical illness in the precipitation of neuroses that he coined the term "pathoneuroses" to describe neuroses so initiated. Anna Freud (1952) has made valuable contributions to the study of illness in children,

¹ It is for this reason that, unless psychoanalysis is possible, the rehabilitation therapist or physician has to construct a hypothesis of the impulses the patient was dealing with before the illness, on the basis of events that happened and clues from the patient's statements and past history. For while the patient might be aware of his mood and actions that led to the illness, the actual self-destructive impulse was not conscious at any time.

and a panel was devoted to it at the psychoanalytic meetings in 1958 (Calef, 1959).

The current report is the second in a series devoted to the psychology of convalescence. In our first report, we dealt with the psychological processes of normal convalescence (Krystal and Petty, 1961). In it we discussed the mastery of the anxiety provided by the awareness of the illness through repetition, denial of illness, and regression. We pointed out that the denial of illness makes possible the cooperation of the patient in his recovery. Only later, denial gave way to grieving involved in the decathexis of the lost parts of the previous body image, allowing for a modification of self-representation in such a way as to permit the greatest possible satisfaction under the new circumstances. We emphasized that regression, which in itself may represent one of the most important defensive and recreative values of illness, may affect any ego-function, or sphere of libidinal organization. The restorative value of regression has not received attention commensurate with its importance. Recently, Lipson and Petty (1961) pointed out that transient regression and phantasy wish-fulfillment are a continuous process, necessary for the maintenance of logical thinking. Virginia Woolf (1948) reflected upon feeling and states occurring in illness, and found that our language provided no words for their description or expression. In order to put into words what she felt, "a new language" was needed. This perceptive author described such a language as follows: It would have to be—

. . . more primitive, more sensual, more obscene, but a new hierarchy of passions; love must be deposed in favor of a temperature of 104; jealousy give place to the pangs of sciatica; sleeplessness play the part of the villain, and the hero become a white liquid with a sweet taste . . . [p. 11].

This is as beautiful a description of the essence of regression as one might conceive. Virginia Woolf (1948), however, went even further, perceiving the freedom from restraint, prohibition, and introversion engendered in the regression:

In health the genial pretence must be kept up and the effort renewed to communicate, to civilize, to share, to cultivate the desert, educate the native, to work together by day, and by night to sport. In illness this make-believe ceases. Directly the bed is called for, or sunk deep

among pillows in our chair we raise our feet even an inch above the ground on another, we cease to be soldiers in the army of the upright, we become deserters. They march to battle. We float with the sticks on the stream. . . . [p. 14].

The morbid sensitivity of an ill person allows for the enhancement of joys derived from inner resources, usually neglected. The isolation and withdrawal is conducive to a hypercathexis of memory and phantasy on a level of regression unavailable ordinarily. For instance, the enjoyment of the functions of perception and imagination are often newly discovered by invalids (Shands, 1955). Similarly, in regression passive yearnings and pregenital libidinal striving are granted fulfillment.

The outcome of normal convalescence is to form a new self-representation (Krystal and Petty, 1961), that is, the addition of the illness and its effects to the former image of the self together with the surrender of the lost function and/or parts. In that feeling which expresses itself in the thought, "and in spite of all I survive," narcissistic omnipotence is restored to an important extent, which contributes to the normal sense of security. The long-suffering patient feels that he has, like a good child, subjected himself to all the punishment and unpleasant treatment fated to him by God and dispensed by the doctor, and he therefore "deserves" happiness.

Final stages of convalescence are pleasurable, at least from some standpoints; the greater self-acceptance is experienced as a major accomplishment and proof of "stamina." The pleasure probably comes from the saving of energy previously required to maintain the repression in the denial of selfhood to one's illness, and other pathological measures which it comes to replace. The patient may also derive joy from finding himself still acceptable and attractive to his environment, and may, in fact, use his doctors and nurses to test his acceptability (Hamburg, Hamburg and Goza, 1953).

The patient frequently utilizes the new situation for the fulfillment of neurotically determined wishes, and the very utilization of this situation depends on the denial of his responsibility for the change. This would be true of those cases in which there is strong reaction-formation against passivity, but where the patients allow themselves to be cared for as invalids since the illness was something they were in no way responsible for. The secondary gain in illness

is made possible by the effectiveness of *repression* despite acting out of *repressed* strivings in becoming ill or in convalescence.

On the other hand, the illness itself may present a situation not acceptable to the patient—at least not without some doing. This may be through the enforced dependency if one is not free to indulge it, through castration implications, narcissistic injury in the illness, or a major loss of limb, function, or expressive facilities. While physiological healing takes place, the patient's efforts are extended to resolve those conflicts. These efforts represent the process of convalescence, psychologically speaking. However, no discussion of convalescence can be fruitful without the constant awareness that often the very onset and meaning of illness to the individual is experienced in terms of and in reference to the premorbid stress and the unconscious phantasy which was stimulated by it. When patients, and particularly children, are interrogated about their ideas of the cause of illness, a reference to the current life situation is invariably made (Beverly, 1936). The possibility is raised that a phantasy of direct wish-fulfillment accompanies states of tension in the adult, just as it had been postulated for the infant. These phantasies are preconscious and reach the patient's awareness only under special circumstances. They become observable through acting out, and break through as a potent force determining the outcome of convalescence because of the regression involved. The breakthrough of a phantasy in illness does not imply that the contents become consciously known to the patient.

Illustration:

A woman who had been in analysis for one and a half years because of a mild depression and anxiety, recalled that on the day before her hysterectomy for myomatous tumors she had a peculiar experience: she suddenly felt her womb "drop." She described the feeling at the time as being exactly the same as the engagement of the child's head in her pregnancy in the past. Thus, the wish was expressed: "This is not a tumor but a baby, and I will have a delivery instead of an operation tomorrow." The wish did not become conscious, however, until some years later in the course of her analysis.

The above case illustrates the use of a phantasy to deny illness. Denial of illness has been described in great detail, as it may involve extensive modification of thinking and speech patterns (Weinstein

and Kahn, 1955). Probably the absence of words to describe illness previously commented upon in relation to the essay by Virginia Woolf (1948) is also a result of our need to deny illness, at times by ignoring it to the point of hypomanic preoccupation with everything else.

Convalescence, from the psychological point of view, takes place as a full process only when the illness involves some loss. It represents essentially a mastery and adjustment to the loss. The steps, defenses and reactions taking place here have been described by Shands (1955), Krystal and Petty (1961), and others (Hamburg, Hamburg and Goza, 1953; Weinstein and Kahn, 1955). Briefly, they consist of a shock reaction, a period of regression with denial of illness, finally, grieving and a new self-representation formation (Krystal and Petty, 1961; Shands, 1955). Each of the above operations is usually self-limited, and persists or becomes excessive usually through the involvement of the idea of the illness with pre-existing conflicts or strivings.

Complications of convalescence, which have been previously described as distinct entities, such as invalidism or precipitation of neurosis or psychosis by illness, can be conceptualized as a miscarriage of one of the normal processes of convalescence. As in physical illness, the disturbing symptoms may be caused by the compensatory reaction set off by the original disturbance. In the psychological aspects of convalescence, its normal processes may become excessive, snowball into an overwhelming panic, depression, or regression, or persist long after the termination of convalescence. In each case, the premorbid personality, the adequacy and flexibility of certain ego functions, as well as other personality factors, will represent the major determinants of the outcome of convalescence. Presently, we wish to emphasize the influence of premorbid phantasy which breaks through as a modification of the normal process of convalescence.

A common type of premorbid phantasy is the masochistically based passive fulfillment wish. Jensen and Petty (1958) have demonstrated that the wish to be rescued, and thus reassured of love by the object, is a dominant force in the mode and outcome of suicide attempts. Such strivings are prominent in illness and traumatic injuries. The patient at times appears to have the wish to *force* the love object (and later in transference the doctor, the hospital, etc.) to take care of him by making himself helpless. Thus the unconscious sequence

of the rescue-phantasy in the invalid is: "Now I am helpless and you *have to take care of me.*" Where the premorbid phantasy involves ego-syntonic passive yearnings, the patient may be not only exceedingly demanding during the hospitalization but also have a tendency to exploit the secondary gain in helplessness. This type of patient tends to show no interest in an active effort to recover, but often becomes an invalid. To illustrate:

C. H. is a 58-year-old woman who came to the McGregor Center following the supracondylar amputation of her right leg. Divorced for six years, she lived alone. The patient gave a history of three strokes (no apparent neurological deficit except a considerable memory defect), and a history of "tapeworms which caused (her) to foam at the mouth."

A review of the past history from the files of the Medical Outpatient Clinic revealed that the patient used to come back every month with complaints for which the doctors could find "no organic basis," and dispensed to her vitamins and phenobarbital. On one occasion the patient told the doctor that she had a "coronary thrombosis," but no evidence was found, and the history showed "heart pounding with headache." On another occasion she told the physician she had passed a tapeworm with "eyes and mouth." Later, she described to us the incident as "doctor found a tapeworm in my belly; it was as big as an orange; he first crushed it with his hands; I passed it—it looked like a sausage."

Since admission to our hospital, all these ideas "disappeared"; the patient was very cooperative, passive yet not demanding. She had a habit of complaining to the nurse about little misdemeanors of her wardmates in a fashion suggestive of sibling rivalry.

The amputation had become necessary because of gangrene of the toes, secondary to arteriosclerosis due to diabetes. At first the patient objected to amputation, but after the operation, would make a point of going around, talking to patients to whom amputation was recommended, showing herself as an example. She had heard that tobacco caused people to lose their limbs and objected to anyone's smoking on the ward.

When the patient was given a prosthesis, her demeanor changed markedly. She became quite belligerent, maintaining that she could not use it because she was "too weak" and the prosthesis was "too heavy." She refused to practice walking, and did not cooperate in physiotherapy. On one occasion, she put on the prosthesis and walked by herself—she fell twice. When admonished that she was told not to attempt walking by herself, she said she "had forgotten" those instructions. When interviewed, she made a slip—instead of saying, "everyone is pushing me

here," she said, "everyone is pushing me *home*"—thereby indicating the real objection to learning to walk. Only when reassured that we would continue to make plans for her and help her was she able to learn walking.

In the above case, the regression facilitated by the illness made possible the expression of masochistic and passive strivings in what could have led to lifelong invalidism. Psychoanalysis of individuals who have had a serious illness, injury, or other misfortunes during childhood, or of individuals who have been subjected to severe illness during their adult lives over a long period of time, suggests that such experiences leave an indelible mark on their character structures, often of a masochistic type. Conceiving the meaning of the illness as a punishment provides a pattern for expiation of guilt, in some cases necessitating permanent invalidism or periodic self-punishment by further illness or addiction to accidents or operations. To illustrate:

A woman was treated psychotherapeutically for eight years for symptoms of panic reaction, agoraphobia, and obsessional symptoms. Actually, she presented a borderline paranoid schizophrenic picture, with periodic breakdown of her obsessive-compulsive defenses. She had a severe masochistic character problem which manifested itself in her various fears, such as fear of her own death or that of her relatives. Among her most troublesome problems was the feeling that she was so bad and sinful that she did not deserve to receive any help, for if God had forgiven her, she wouldn't have her problems. At the same time, she was constantly preoccupied with doubts about God, her church, her parents, and in the transference, her therapist.

Late in her treatment it became possible to deal with a severe trauma of her childhood: at the age of four she developed diphtheria. She was taken to the municipal hospital where she had to be intubated in order to prevent suffocation. Her parents were not allowed to visit her. In reconstruction, it became apparent that as a child the patient blamed her mother for abandoning her. She handled her reaction by feeling that she must have been punished for her own death wishes. While there were later reinforcements to these feelings, the patient formed, at this point, the groundwork for a very rigid masochistic character structure, as a defense against her aggression, as well as a full-blown obsessive-compulsive neurosis. Although neurotic, she functioned fairly well for a number of years through her participation and devotion to a fundamentalist church. When, however, during her early adulthood, she lost the support of the

church and was seriously disappointed in its clergy, the patient's defenses crumbled and paranoid symptoms appeared.

The effect of illness as a shaper of character is especially great in childhood. Observations of children in relation to illnesses show clearly that the premorbid stresses refer to the patient's psychic reality, linking the traumatic events to the predominant psychic conflicts and phantasies. The following excerpt from an adult analysis illustrates this point:

The patient, a young adult male, recalled in analysis an incident from childhood, when under anesthesia for a tonsillectomy, he had dreamed that he was being painfully squeezed between two twin beds. The patient's association identified the beds as those of his parents. Prior to his tonsillectomy, he slept in his mother's bed. The mother apparently used him to prevent or control his father's sexual advances, literally and figuratively "putting him in the middle." He had witnessed the primal scene, which he experienced as his father's attack upon his mother, and felt she "was being hurt and cried out in pain." Thus, when he was "attacked" by the surgeon, his masochistic feminine identification was lent the force of reality.

An illness in childhood which becomes a significant influence in the characterological development of the child, of course, is not always one that happens to him personally. Illness, or accidents in children's love objects can become similarly involved, supporting fears of one's wishes or punishment for them.

Significant in the influence of illness on the child's development is the effect of the mother-child relation around illness. When the child is in pain, he calls for immediate relief brought by his mother. The mother, by a gentle rather than angry response, allows illness as an acceptable form of living. At least in one analytic case, the patient experienced great guilt over physical illness as a form of misbehavior; in this, she identified with her mother, who reacted similarly toward her. In fact, the particular illness she developed later was related to introjected rage.

When a mother responds to the child's cry for help because of illness or injury, she does so by holding him warmly and securely, and by comforting him. Meanwhile, time passes and the pain may stop. Thus, the child's lack of understanding of time lends reality

to his beliefs in the parent's magical powers. These feelings, which are later transferred by the patient to his physician, serve as the basis for the "placebo effect" (Dorsey, 1961). In this connection, the medications given by the mother, along with the nursing ritual set up by her, both come to represent substitutes for her, always available and maneuverable. Thus there is established, for some individuals, the predisposition to the syndrome combining obsessive-compulsive traits with addiction to alcohol or other drugs.

A. Freud (1952) pointed out that the diseased part of the child is identified with himself as the infant, whereas another part assumes the role of the mother. This ego split, which was confirmed in our previous study (Krystal and Petty, 1961), is the prototype of all therapeutic situations, especially well known in psychoanalysis. Childhood illness allows for the projection of ambivalent feelings upon an organ, including the attitude toward the organ as the "bad" (introjected) mother. The following case illustrates this point:

A 23-year-old college student was referred because of inability to study or concentrate. He was a very handsome, tall man with blonde wavy hair. For the last 10 years he had gradually been losing his vision. The blindness was hereditary on his mother's side of the family. For the last two-three years, the patient suffered severe hypochondriasis with two predominant preoccupations: that he was constipated and unable to get "cleaned out," and that his skin was getting oily and he was losing his hair. He was tremendously upset over the loss of his hair, which was exceptionally attractive. Severe constipation and partial baldness were found to be characteristics of the patient's mother. Thus, along with the pathological identification with the mother caused by his resentment of the burdensome inheritance, he hypercathected all parts of himself corresponding to her pathology. His guilt and ambivalence in relation to the mother was acted out in relation to his "supercharged" organs.

The loss of such an ambivalently charged organ often leads to "pathological mourning" of it in a prolonged depression. Apparently closely related to such pathological identifications is the phenomenon of the "painful phantom" in amputations (Kolb, 1954). The mental representation of a lost, and thereby hypercathected, organ can be used for hallucinatory projection of the dreaded mutilation of one's self (Krystal and Petty, 1961).

Persistent withdrawal from normal social contacts was observed

in narcissistic individuals who suffered a visible disfiguration. The individual predisposition consisted in a narcissistic overvaluation of one aspect of one's self—most commonly, appearance.

Illustration:

A handsome ex-marine suffered a laceration of his face, which resulted in a scar of his left cheek and chin. Upon return home, he broke his engagement as he felt his *fiancée* would "abhor him." He felt that people were shocked by his appearance and quit one job after the other because he could not stand people "looking" at him. He avoided all social contacts. On one occasion, when coaxed into attending a relative's wedding, he left a girl in the middle of the dance floor and ran away when the dancing partner asked him how he got his scar. Upon completion of his interview, he walked up to the mirror in the room and combed his wavy hair before he left.

Of course, such an overinvestment is already pathological, often serving as a way to ward off a latent depression.

A patient who was basically rejected by her mother learned to gain some recognition by being witty and exploiting her physical beauty. This resulted in an overinvestment of her femininity as a channel leading to oral and other gratifications. After a hysterectomy, a serious depression ensued which necessitated confrontation with the basic feeling of rejection.

Ferenczi pointed out that pathological hypercathexis of an organ might predispose to psychotic reactions in convalescence. Psychosis and suicide are not rare postoperative complications. Somewhat less common, if we do not count the transient periods of depersonalization, is the occurrence of psychosis in acute illnesses and following traumatic injuries (Cobb and McDermott, 1938; Abeles, 1938). We cannot account for this quantitative difference in any other way except to consider the "benefits" of surgery mobilizing unconscious guilt previously expiated by chronic illness. The following newspaper clipping¹ suggests self-destructive impulses in a person after regaining sight:

BLIND MAN DIES IN LEAP AT HOSPITAL: A 47-year-old blind man, who had expressed happiness over what appeared to be a successful eye operation, leaped to his death from a sixth floor restroom

¹ *The Detroit News*, August 20, 1960.

at the hospital today. C.H., blind since lye accidentally spattered in his face a year ago, fell to the roof of a one-story hospital wing. He had undergone a cornea transplant in his right eye . . . the bandages had been removed yesterday and C.H. had been able to discern colors. Dr. M., who visited C.H. half an hour before his leap, said he "seemed very happy about the prospects of regaining full sight in the eye."

Many of the factors leading to regression may be involved in precipitation of psychosis and will not be discussed at this point, except to emphasize that of the forces involved, the combination of the castration implication of illness, together with the pathogenic investment of libido in an organ, favors the development of hypochondriasis or even paranoid estrangement of parts of the body. Ferenczi (1953) stated that if the individual's ego defends against "the localized increase in libido by means of repression, then an hysterical pathoneurosis might ensue; but if there is complete identification with the affected organ, then a narcissistic pathoneurosis or simple disease narcissism may be the result of illness." He postulated the following three circumstances that would have the potential to lead into a psychosis:

- (1) If the constitutional narcissism—even if it be only latent—was already too powerful before the injury, so that the slightest harm to any part of the body affect the ego as a whole;
- (2) If the trauma endangers life or it is thought to do so, that is to say, threatens existence (ego);
- (3) If one can imagine the formation of a *narcissistic regression or neurosis of this kind as a result of an injury to a part of the body especially charged with libido, with which the ego as a whole easily identifies itself* [author's italics].

The current experience indicates that the organ thus "overcharged" with libido is in fact experienced very ambivalently. The organ is at once the most prized "possession," and the source of pain—i.e., the persecutor. The patient often projects all his dysphoric feeling upon the organ, including guilt. The loss of such hypochondrical defense may result in a psychosis. Thus the classical observation of Jelliffe and others, of patients who, upon recovery from their organic illnesses, lost their sanity (Dunbar, 1943; Jelliffe, 1930). If one considers the type of premorbid phantasy that contains aggressive wishes (death wishes) toward one's love object, one outcome becomes apparent:

that at times the patient may need to render himself helpless to protect the love object (Bak, 1954)—such defenses contribute to further invalidism.

In our patient population, the aggression originally “directed” toward one’s love object was *turned against the self*. The anxiety was caused by the sentience of one’s aggression and guilt—insofar as the object of the death wish has been the love object. There is often an attempt to allay this anxiety through neurotic symptoms.

M.S. was a 58-year-old woman, married for 40 years and a mother of six. The marriage was markedly sadomasochistic, and the patient would take a lot of verbal abuse, acting out her aggression almost exclusively in turning her children against their father. A few months before the onset of the illness, the fifth child married, leaving only one at home. The patient’s husband talked of retirement after his grandson’s bar mitzvah, which took place on the day of the onset of the prodromal symptoms. For one year prior to this, he had been staying home more, the patient spending most of the time in her room. The patient’s husband suggested that the unmarried son take over his business, but the patient objected and effectively prevented it on the pretext that the father would abuse the son. There was some justification of this in reality.

While attending the bar mitzvah ceremony, the husband kept making loud, critical remarks about the patient. He had been quite abusive of her and the single son that morning. During the ceremony the patient developed a sharp pain in her chest. She had anginal pain on exertion during the following week. On the following Sunday the family had a visitor. During the conversation, and in the presence of both the patient and the son, the husband persisted in making deprecatory remarks about the son. The patient developed severe pain in her chest. Within the hour, her blood pressure fell to near-shock levels, and she was taken to the hospital where a myocardial infarction was diagnosed. At the time of the onset of illness, the patient became extremely anxious. Later, she was quite depressed and “resigned.” The patient was conscious of her anger with her husband whose behavior she “couldn’t take any more.”

One of the patient’s daughters related later that the patient called her up on the telephone the morning preceding the onset of the illness and hinted that she was “through,” that she felt “that’s the end.”

Following her discharge from the hospital, the patient did not go home, but stayed with a married daughter as long as she felt welcome there. Two months later the patient’s husband had to be hospitalized for a chronic illness. The patient became depressed, expressing her guilt in

relation to her husband; she indicated that she felt responsible for his illness and that she could have prevented it had she "taken better care of him."

The above case also illustrates a "side-effect" not uncommon in illness: a type of regression which favors the "resomatization" (in the sense of Schur, 1955) of anxiety. Once the patient develops certain symptoms associated with a component of anxiety (e.g., anginal pain in the above patient as a result of vasoconstriction), affects which could not be expressed directly, such as anger, now obtain expression directly. Having found a channel for the expression of such affects, the patient may make it a permanent mode of reaction. However, this reaction may be accompanied by the patient's fear of destroying himself with his own anger, if the causal relation becomes apparent to him. A special case represents the patient's fear of becoming afraid. The situation is special because the patient is in fact able to produce the state he fears by the conscious concern about it, in contrast say, to instances of cancerophobia.

A 39-year-old cab driver presented himself with symptoms of hyperventilation and anxiety. He was an inhibited and passive individual. He married a girl who thought she had become pregnant by another man, "to give the child a name," but when the enlargement of the belly turned out to be a tumor, the woman left and divorced him. He lived alone until a year prior to the onset of his present symptoms, when he married a woman older than himself, and the mother of 13 children—several of whom were still at home and dependent. The woman, a very bossy and argumentative person, was also a cab driver, who often earned more than he did and made a point of it. One day, while he was quite uncomfortable with the gastric "flu," he was hired, after a long wait, by a nagging woman passenger who irritated him, and after going for a short trip, which meant little earning for him, she left him without a tip. The patient developed anxiety and a period of hyperventilation which he considered to be a "heart attack." Within a few months, and despite many visits to doctors, the patient had several repetitions of the hyperventilation "attack." He lived in constant fear of it, gave up his job, and became sexually impotent. In psychotherapy, it became apparent that his fear was basically of his suppressed anger. It became very difficult to break up the vicious circle of a fear-of-fear and its production, even with the use of drugs. Because of the secondary gain, the patient had reasons for hanging on to it. The crucial point, however, was that he could not be

reassured against his fears, since he would lapse into them whenever he started to think or worry about them.

In considering the psychological "side effects" of illness and misfortune, we must consider the fear which is provoked. Said Metastasio, "The worst of every evil is the fear." The fear becomes the symptom of reintensification of latent feelings of guilt, and thus exerts pressure toward emotional regression. In discussing the causes of regression in normal convalescence, we considered the dynamics of the following consequences of illness: (a) enforced helplessness; (b) narcissistic withdrawal; (c) pathogenic hypochondriasis; and (d) revival of unconscious guilt and castration anxiety. Regression, transient and in the service of the ego, is probably a most important defensive aspect of "being ill." Each and all of those consequences of illness, but most importantly the revival of castration anxiety and return of the guilt of the original childhood neurosis, can lead to regression of the patient during the illness, and may potentially precipitate the onset of a neurosis or psychosis (Krystal and Petty, 1961).

One of the most common complications of convalescence is the persistence of the denial of illness. The symptoms can be organized into the following types:

(a) The "quack-seeker," seeking out and supporting faith healers, cultists, etc., in spite of many authoritative opinions, thereby precluding further help because of an inability to tolerate this reality. In this group, we observed that unresolved transference reactions to the physician apparently play an important etiologic role in the patient's persistent search for the "good mother."

(b) The "compensator," acting out the denial of fancied or real mutilation in aggressive or erotomanic activity. Particularly in the nymphomaniac or satyriac patient, one observes denial of castration implications of illness—the acting out being a means of avoiding a neurosis.

(c) The "crusader," compulsively fighting the illness to which he has succumbed. In this group are notable personalities who have been able to utilize this reaction constructively. Among them, cancer fighters and members of Alcoholics Anonymous figure prominently. The compulsive nature of this defense, however, makes their position brittle and vulnerable.

(d) The "paranoid denier," projecting the responsibility for the

illness upon the doctor, hospital, etc. These patients delight in and press litigations intended to prove their "innocence" in the causation of illness, and to insure a permanent passive masochistic relation. As we have pointed out in our previous paper on this subject (Krystal and Petty, 1961), this way of dealing with one's illness is also a function of unresolved transferences.

Illness may cause a distortion of self-perception to the point of depersonalization. In his study of Giorgio de Chirico, Krystal (1966) has described the modification of self-perception and the perception of the environment in this artist. Following his migration and development of an "intestinal illness," Giorgio de Chirico perceived the world in a state so altered that when pictured in his paintings, de Chirico made a profound impression upon the world and in art with his famous "Chirico City." Hazlitt (1904) has described the convalescent state as follows:

It is curious that on coming out of a sickroom where one has been pent up for some time and grown weak and nervous, and looking at Nature for the first time, the objects that present themselves have a very questionable and spectral appearance: the people in the street resemble flies crawling about and seem scarce half alive. It is we who are just risen from a torpid and unwholesome state, and who impart our imperfect feelings of existence, health and motion to others. Or it may be that the violence and exertion of the pain we have gone through make common everyday objects seem unreal and unsubstantial. It is not till we have established ourselves in form in the sitting-room, wheeled round the armchair to the fire (for this makes part of our re-introduction to the ordinary modes of being in all seasons), felt our appetite return, and taken up a book, that we can be considered as at all restored to ourselves. And even then our first sensations are rather empirical than positive; as after sleep we stretch out our hands to know whether we are awake [p. 97].

In the totality of the syndromes related to the persistence of denial of illness, the nature of the unresolved transferences to the physician play an important role. The doctor who is confronted with an imperfectly recovered patient may protect himself against a narcissistic blow by projecting his failure upon the patient. Such a counter-transference situation may lead to a sadomasochistic acting out. Not infrequently, the doctor's manner of communicating to the patient that nothing further can be done for him reveals that this statement

is not only a partial truth but a total rejection as well. The patient may make use of the fact of rejection to deny his illness extensively.

The intensity and persistence of denial of illness in lesions of the central nervous system and essential sensory organs is so conspicuous that it attracted much descriptive work (Weinstein and Kahn, 1955). Similarly disposed is an individual whose illness affects an organ which is highly prized, on which is invested with much bodily libido. Organs of the body of which one is usually not aware, provoke little denial reaction upon their loss. Conspicuous in such patients is their failure to follow orders of restriction of activities or other precautions. Generally speaking, the persistence of denial represents a failure in the ego's dealing with the loss and mortification.

The patient who before the onset of the illness is involved in fighting off his "loss of status," and especially a patient forcibly retired to whom the work was a tie to reality or a way to prove his masculinity, is particularly apt to have difficulty in accepting his loss.

H.S. was an 82-year-old widower. He had been a successful printer, whose business was recently taken over completely by his son and daughter. Before the illness, he spent most of his time in his shop. In the hospital he showed many regressive attitudes. He would, for instance, refuse to bathe and generally was childish, often flippant or obstinate with nurses. He seemed to be unable to admit to himself the fact of illness, but wanted to "return to work" and to continue running the shop. On several occasions the patient would dress and insist that he was "going to the office." On one occasion he wandered off the hospital premises and was found the next day in a cheap hotel, his money and watch missing. He would constantly try to get away from the hospital, and finally arrangements were made to send him periodically to his shop.

The patient tore off his cast several times and refused to wear a splint. This behavior finally resulted in a radial nerve paralysis and rendered his hand useless.

The above-described patient was so involved in denying his senility that he continued to deny the new injury to the point of causing further damage. In some patients, inability to acknowledge the illness is due less to the symbolic meaning of the illness (narcissistic injury, symbolic castration) than to fear of acknowledging the illness as a punishment for the aggression involved in the premorbid phantasy. Thus the effect of the illness is often determined by the psychic reality which is the matrix for the unconscious implications one

must master with the onset of illness. *The premorbid unconscious phantasy appears to be the particular mental event which causes a subjective association of the premorbid stressful situation with the new trauma and new reality produced by the illness.* It is involved in the occurrence of many of the complications of convalescence. On the other hand, the unconscious phantasy an individual nurtures before the onset of an illness makes it possible for him, at times, to use the awareness of the illness to maintain or restore his ego defenses to a condition as stable as or better than before the onset of the premorbid stress. This is made possible through experiencing the illness as punishment or the fulfillment of an unconscious wish.

Summary

A psychoanalytic study of the complications of convalescence shows the tendency of illness to revive guilt and castration anxiety, thus forcing regression. The awareness of illness becomes associated with current psychic reality, especially phantasy wish-fulfillment, and elimination of hated objects. Thus, the onset of illness can be terrifying in that it may represent the fulfilled wish or punishment for it. A variety of complications of convalescence is discussed, including characterological changes (masochistic and others), invalidism, the continued denial of illness, and precipitation of various mental illnesses. Illness and convalescence in childhood, because of its universality, appears to be a most important determinant in future personality development.

SOCIAL SERVICES AND REHABILITATION PROGRAMS IN THE SURVIVOR SYNDROME

DR. PETTY:

As you have all discovered in working with the particular kind of patients we are talking about today, it is not enough to utilize 45-50 minutes of free verbalization in an office for interpretation and then expect the patient to use that interpretation for improvement, let alone recovery. Many ancillary services are necessary if the desired goals are to be achieved. We are going to consider some of these ancillary services, which are popularly subsumed under the heading of

rehabilitation services, and which include all measures utilized by a patient in recovering his health.

As most of you know, for many years we at McGregor Center have been concerned with rehabilitation and health education. Recently, a day-hospital service was added to our program and the 24-hour hospital service was discontinued. The psychological services for adults and children have been expanded, as have the health-education facilities for professionals in the field.

During the period of time the general convalescent and rehabilitative hospital services were operated, they were under the direction of psychiatrists who utilized extensively the services of clinical psychologists and social workers. This pattern of operation made possible some observations especially pertinent to the subject of our discussion today: the psychological concomitants of illness, physical injury, convalescence, and rehabilitation.

The patients of our study were self-selected on the basis of having undergone a personal disaster—the only feature which they held in common. The personal disaster might have been an injury, an illness, or an accident which resulted in a chronic illness, or some other irreversible physical loss. They came from a broad range of geographical locations, social strata, and age groups. None of them had been subject to mass disaster, either natural or man-made. However, it requires no stretch of the imagination to appreciate that a population struck by disaster or chronically mistreated will present individuals who, by reason of this common experience, will have similar clinical pictures and diagnoses, and will require comparable therapeutic measures.

DR. KRYSTAL:

In comparing the reactions to private disaster of our rehabilitation patients, to the reactions of those who survived Nazi persecution or the Hiroshima bombing, some observations seem pertinent to our discussion today:

(1) The temporary suspension of ego functions so readily observed by us in the acute stages of illness were not as clearly described in the studies of 20 years ago on the survivors of the Nazi persecution and the Hiroshima disaster. However with some confidence we venture a guess that such reactions as depersonalization and derealization

were probably common if not the norm in the individual's response to these disasters.

(2) The denial of illness which we found in our patients is probably a universal phenomenon and has a corresponding reaction in all other overwhelming experiences. Bettelheim (1960) has emphasized the massive denial of disaster in the Jewish reaction to the Nazi assault. When the danger is overwhelming, and nothing can be done about it, denial is inevitable. Denial of death is our common condition. On the other hand, we were aware, in our rehabilitation population, of the process referred to as psychological closure by Lifton, or automatization and robotization referred to by Niederland and Krystal. The impression was that the narcissistic regression made it impossible for the patient to "pay attention" to things outside of himself. Hamburg (1953) has pointed out that a woman suffering from severe burns had to "ignore" the simultaneous death of her husband by fire in the Coconut Grove disaster. However, the usual patient's "closing off" may be missed because of a tendency to identify with the hospital routine rather than with the patient's task in having to adapt to that routine. Thus, the care and attention provided patients in hospitals for chronic illness, might benefit by the direct application of knowledge acquired through the investigation of massive traumatization. In addition, what has been learned about the effect of deprivation of liberty, and the imposition of confinement in creating severe psychic stress, has immediate application for the chronic disease hospital.

(3) The mourning reaction discussed elsewhere in this volume (Chapter 3), in regard to the lost love objects, reappears in our studies of the reactions to the loss of limb, organ, or function. Every loss, whether of a part, capability, capacity, or aspect of oneself, has to be grieved through a mental process analogous to mourning. This fact has immediate application in the assessment of function and adaptation of the survivors of Nazi persecution. Following their liberation, the survivors were faced with the necessity of adjusting to (mourning) the loss of family, relatives, community, and world. In addition, the survivor might be confronted with adjusting to (mourning) the loss of youth and its pleasures, the loss of capacity for experiencing pleasure, the loss of "good looks," the loss of other developed and potential capacities such as peer relationships, community status, religious beliefs, etc. A person can tolerate only a limited amount of mourning

without becoming severely depressed. When this threshold is reached, further mourning may be warded off by the use of denial. The inability to mourn or the development of pathological mourning in regard to the loss of a part or an aspect of oneself seems to be identical to the inability to mourn the loss of a loved object. This phenomenon focuses our attention on the self-representation as an object and its analogy to the process of rehabilitation after a massive disaster. In the course of rehabilitation from a serious physical affliction, it is apparent that unless the patient is able to withdraw his cathectic investment from the parts or functions lost, he will not have the energy or capacity available for relearning and readjustment. With this observation in mind, let us consider the problems of "the survivor."

The "survivor," having unresolved problems of mourning and, in fact, being in a state of pathological mourning, is greatly threatened by any new loss. It is self-evident that the loss of a current love-object mobilizes all the latent conflicts and threatens to overwhelm these patients with depression. As a result, they will typically participate in funerals and bereavements "without any feelings," and tend to deny their losses, (but may develop insomnia, depression, or hypomania and sleeping pill abuse immediately thereafter). At the same time, however, they suffer chronic depression, and the feelings blocked upon bereavement frequently "spill" in an isolated fashion upon encounter with diffuse trivial stimuli.

What we have found, however, and this is the reason for our discussing the matter of physical loss, is that in the survivor syndrome every loss of one's physical function, capacity, or attribute is experienced exactly as the loss of a love object and consequently threatens the same kind of overwhelming depressive or psychotic disaster. Their very response to any illness or misfortune is with panic that implies that the persecutions have "returned." In the patients who do not become severely depressed, we see an extreme denial of illness. For instance, a concentration-camp survivor who had lost his entire left lower limb emphasized repeatedly that, with his prosthesis, he can do "everything any other man can do," or a paraplegic insists on "running" his business, in which his entire family conspires to maintain the pretense that he does so.

It becomes equally apparent that the failure to work through the mourning of his loss is an important cause of the impoverishment

and constriction of interest in the survivor's present life. The life still becomes anhedonic, with a loss of capacity for enjoyment. Thus, in treatment, working through the mourning of loss is a major curative factor.

(4) It may be a surprise to those of you who have worked exclusively with the problems of disaster survivors that guilt should constitute a serious problem in individual illness and injury. In our previous paper (1961) on the subject of normal convalescence, Dr. Petty and I considered in some detail the problems of guilt in convalescence. We pointed out that the universal question, "Why did this happen to me?" causes the revival of guilt on many levels. Two of the most important sources of this guilt were related to the phantasy fulfillment of ambitions unconsciously experienced in oedipal terms and to the effects of the "premorbid phantasy." In the latter category, we found that aggressive impulses toward individual objects, as well as primitive incorporative or sadistic impulses, may become involved in causing serious complication in recovery because illness or crippling may be necessary as a punishment or to protect the love-objects from one's aggression. A parallel phenomenon is observable in the survivor in relation to the destruction of the members of his family, community, and even his "world," and fear of his aggression hurting his new family.

It is easy to see the parallels between the reactions and complications in the process of convalescence from serious physical affliction, and those following the individual's recovery from a mass disaster, the latter creating the additional effect of loss of support, implications of "end of the world" meaning, and likelihood of helplessness.

(5) Finally, let us consider the question of causality and its forensic implications. The precipitation of neurosis and psychosis by physical illness, accidents, and surgical operations has been documented by the many studies quoted in the paper you have just heard. If this is the case, as it obviously seems to be, then it is no great assumption to consider that mass disaster, persecution, and genocidal attacks could be more stressful and potentially more pathogenic. In illness and injury, long-term complications develop in those individuals whose tolerance and ability to maintain psychological homeostasis has been exceeded by the psychic reality of their personal loss. Everyone has some limits to his tolerance, resources, and adaptability. It requires no stretch of the imagination to realize that some stressful

situations could be so overwhelming that serious pathology would result in most, if not all, of those who were subject to it.

Our observations on the use of denial of physical illness and injury demonstrate that denial of loss and limitation can become prolonged and even a life-long mode of adjustment. Consider then the survivor of persecution who has an additional motivation for denial that our patients did not have; that is, the conviction that to admit damage is to acknowledge the victory of the hated oppressor and to deepen the feelings of self-disparagement and disgust. We have been impressed that the survivor's feeling, "Despite it all I survived," is equally important as a means of restoring self-respect and overcoming passivity in the ill and injured as in the survivor. Acknowledging damage when confronted by the malevolent oppressor threatens this source of strength which is the only semblance of triumph.

DR. PETTY:

You have just heard observations made in the process of rehabilitation. We want to devote our session to a discussion of the process and problems of rehabilitation. To start things off, I would like to ask Dr. Niederland to initiate the discussion with a presentation of his experiences in Altro.

DR. NIEDERLAND:

I am indeed grateful for this opportunity to discuss with you some of the aspects of our work at the Altro Health and Rehabilitation Services, because it involves psychotherapeutic and various more direct rehabilitation efforts on behalf of survivors of Nazi persecution, among others.

We are still groping in these efforts, for the following reason: among the main tools of rehabilitation is industrial retraining, which often involves a period of work in a sheltered workshop. The work factor itself represents a serious problem to many of these severely damaged victims because their persecution was related to coercive work. They were taken to forced labor, first in the ghettos, later in ammunition factories to promote the Nazi war effort, and finally in concentration camps where they were forced to work as long as they had any strength left. Upon arrival in the camp, the children, the weaker siblings, and the parents were often separated from those who could work, and were exterminated in one or two days. Those who

were found suitable for work during these murderous selections were put into forced labor, and they owe their survival to the fact that they could perform for the Nazi war machine. You can imagine what the return to work under supervision means to them—how it is permeated by and overlaid with conflicting factors, with the intense emotionally charged response to the work situation. Social workers may have observed more than I how inimical were the initial responses of these survivors. They develop a hostile transference, experience the work supervisor as a Capo, and suffer a revival of suppressed aggression which is then projected.

The patients come to Altro after a lengthy period of preparation, since the majority have been discharged from state hospitals. The objections they raise to all suggestions and efforts to return them to the work process are, in my opinion, mobilized by the deeper unconscious factors which I have just briefly described; namely, that work still has for them the connotation of slave labor, of coercion, and all the other violent aspects and losses which were connected with the traumatic situation.

The other difficulty we have encountered in putting these people to work again is related to their actual or felt loss of status, both occupational and social. These people have become hypersensitive to all losses by virtue of the loss of their homes, their family members, their former life roots, their country, and other significant ties. Any situation which seems to resemble a new loss is unconsciously connected with the real losses experienced, so that if for instance, as in the case at Altro, they receive a smaller salary than at an outside situation, naturally they object: "Why do I get only 50¢ per hour?" They know very well, consciously, that this is a sheltered workshop, a therapeutic effort, and that moreover they are paid for the help they receive; nonetheless, a loss is felt and is consciously experienced as anger in response to the loss in earning capacity. However, it really is felt as a new loss resembling the much earlier losses experienced during the persecution.

Over the last 10 years, the Altro Health and Rehabilitation Services have accepted patients suffering from psychiatric illnesses. The Altro Workshop was established in 1913, originally for patients suffering from tuberculosis. In the twenties it also accepted patients with chronic cardiovascular disturbances and other cardiopathies, and about 10-12 years ago it added a department for the rehabilita-

tion of psychiatric patients, especially postpsychotics, people who had suffered psychotic breakdowns or mental breakdowns as it is more popularly called, and who had been hospitalized in mental hospitals. A sheltered workshop has proven helpful to patients before they return to competitive work in industry, especially so for paranoid schizophrenics (as well as other psychotic and postpsychotic patients) because it gives them a period of from six to 18 months in a sheltered setting where there is no actual industrial competition. We have found that a considerable number of patients suffering from psychiatric illnesses, including patients who have previously been hospitalized for many years in state hospitals, can be sufficiently rehabilitated, with the result that our workshop setting becomes for them the first step, so to speak, on the road back to occupational and industrial recovery.

There is now at Altro a Negro woman, for example, who had been a patient of a state hospital for over 30 years. She was 18 or 19 when she had to be hospitalized because of an incapacitating type of schizophrenia. Now, at the age of 50 or so, she works in the Altro workshop and does quite well. However, this does not represent the average case.

The patients who come to Altro for rehabilitation suffer from a variety of mental disorders, and Altro offers them a suitable setting for transitional sheltered work experience—what we call “industrial convalescence”—as well as full diagnostic and vocational evaluation, and to some extent, social and personal rehabilitation. The current Altro program for mentally disturbed patients is considered by us primarily one of vocational retraining and rehabilitation. Fewer than 20 percent of the patients remain in the occupations performed at the workshop. We try to get them used to the climate and atmosphere of work. Originally, after having worked in the workshop for six months or a year, at either a sewing or printing machine, the patient would start to look for employment elsewhere on their own; now, we tend to counsel them and guide them into suitable occupations.

This gives you the general setting at Altro. Returning to our experiences with survivors of concentration camps, as I have already told you, they encounter major difficulties because work as such implies consciously and unconsciously all those adverse connotations which I described before. The foreman is sometimes seen as a former Nazi, although there is no realistic evidence to support this.

If we have up to an 80 percent recovery rate in our general psychiatric population, the recovery rate in former persecution victims is much lower. While I do not know all the statistics—we have only a small group of about 20 or 25—I would estimate that our recovery rate is somewhere between 30-40 percent at best, and frequently lower.

At the present time we have patients who were persecuted by the Nazis, and who were in various state hospitals. One woman, who had a fully developed psychosis and had lost part of her family in Germany, denied that anything had happened. I examined her about a year and a half ago before she was admitted to Altro and she still denied that anything had happened. When I asked her why, after 20 years, she was still in a mental hospital, she replied, “Well, there is no other place for me.” She had no insight into her illness. “This is just my living place.” We had information from the state hospital that she had worked there in the laundry. We took her out of the hospital; she received compensation; she found a room (also sheltered, where the landlady had had such patients before), and she would come regularly to work in the sewing machine department. She didn’t do well at all, and the foreman of the department became angry with me: “How could you send me such a patient? She sits at the sewing machine and in one or two minutes she leaves to go to the bathroom, then she returns and disturbs the other former patients just by sitting around not doing anything, and the whole workshop setting does not help her.” Well, I convinced the foreman to continue and keep trying. The patient did not improve very much but occasionally there was a slight increase in her work output. Instead of going to the bathroom 40 or 50 times a day, she spent only half that number of times in this activity, or she would leave to take a little fresh air, etc. She was given to constant complaining. I must admit I was almost at the point of taking her out of the workshop, yet one thing convinced me to continue for another few months: she did not cause any serious disturbances, and apart from her lack of insight and complete denial that anything was wrong with her, she had no apparent hallucinatory or delusional manifestations. There were just the remnants of a “burnt-out” psychosis. We were able, through our social services, to persuade the Red Cross in New York to accept her as a volunteer worker, rolling bandages. We had had her in the workshop for about a year, and now she has been with

the Red Cross for about eight or nine months. She does a good job all day long, rolling up bandages, packing, shipping, etc., and everyone is very happy with her. Not so long ago, it appeared to have been an almost hopeless situation and we were on the verge of sending her back where she had come from. Frankly, I am at a loss to explain the change, except that in general terms it is indicative of some residual ego strength which perhaps was reinforced by her one year of experience at Altro.

MRS. FENIG:

Perhaps the idea that she is working for the Red Cross may have something to do with her recovery, in that this kind of work has more esteem—she is doing something which is socially more accepted and which is of some benefit.

DR. NIEDERLAND:

I have had similar thoughts on the subject. Admittedly, I have not done a full study of all this, but I have been impressed by what has transpired. Here is someone who, after 20 years in a mental hospital, occupationally is more or less a failure in the workshop without, however, causing real trouble, and who then makes a satisfactory adjustment.

MR. WILLIAM C. GHESQUIERE:

I wonder whether the fulfillment of an altruistic impulse could have been the therapeutic tool. Thus the rolling of bandages would be a kind of giving aid to herself, whom she felt as having been injured—kind of a healing, corrective thing.

DR. NIEDERLAND:

We have thought of this also, and therefore have placed some of our survivors in the shipping department, which sends items made by the sewing department to hospitals all over the country, especially surgical garments and nurses' uniforms, sheets for surgical rooms, etc. Your point is well taken.

When I took over the psychiatric department at Altro, eight years ago, after it had been built up by my distinguished colleague, Dr.

Bellak, we had 17 patients; now we have about 80-100 working regularly, and those who have left are still under our advisory care. In the beginning, I had some doubts, as a psychiatrist, as to whether I could utilize the workshop—with its hustle and bustle, noise, etc., a factory with big machines and potentially harmful tools (needles, sledge hammers, etc.)—as an effective therapeutic tool. I was fearful about the responses of some patients, especially the paranoid ones, but I learned that most of our patients bear up rather well.

REV. SYDNEY BYRNE:

For four years, it was quite some time ago but I've never forgotten my experience working with criminals, particularly in the setting of Recorder's Court, I had similar impressions. I have been trying to arouse the concern of the church in this area because I feel that occupational rehabilitation is important. I notice here a corollary to the kind of attitudes prisoners discharged from incarceration show toward work. They are not too anxious to get started because there is a carry-over from the kind of work they were doing while in prison, when they got about five cents an hour for their efforts. Neither do they like the idea of having to start "from scratch" again, with its implicit loss of status. Even when people are imprisoned for what society says they deserve, they react with anger and resentment as those who have been persecuted unjustly. Thus imprisonment in our society produces psychopathology parallel to the concentration camps.

My role was to be with them from the time they got into trouble until they were released. In my contacts with prisoners, I would try to keep these things going—a desire to work and concern for the family—hoping to prevent a loss of their sense of value and importance. I would visit them once a month in prison to let them know that there was concern for them as individuals. I felt there was value in this type of approach because the respect for the individual is maintained; in the instances where it was possible, I tried to follow them right through, from the time they first got into trouble up to the time they were out on parole. You can do more with them when you pick them up on parole time. The important thing is to show respect for the individual even though he is in trouble.

DR. NIEDERLAND:

We attempt to re-establish the disrupted human ties with the help of teamwork. Apparently, yours is a one-man effort, working without a team; however, the unique nature of your work is the preventive one: you counteract the pathogenic influences of imprisonment.

REV. BYRNE:

I try to keep the chaplains involved in this kind of work. If I am unable to do it myself, I see to it that someone else does. I don't think it is necessary for the same person to do it all the time; the important thing is that the constant respect for the individual is carried on. The time of sentence, I think, is the most important time to be around, because no one else is concerned about it. Quite typically, the family and everybody else all wash their hands of it; they seem to be compelled to do so.

PSYCHIATRIC RESIDENT, *Detroit General Hospital*:

Dr. Niederland, you mentioned the trips to the toilet as the outstanding feature of this patient whose home had been the state hospital for 20 years. Were there not other bits of behavior, and possibly symptoms, that would have suggested incandescence of the psychosis in at least a mild form?

DR. NIEDERLAND:

No, I would say that the "burnt-out" state of the psychosis continued; there was no observable exacerbation with the exception of these peculiar symptoms and the inappropriate behavior. Questions or mild and friendly admonishments were often answered by giggling or not answered at all, and at times the patient walked out in the middle of a conversation, but major psychotic features did not manifest themselves.

RESIDENT PSYCHIATRIST:

The reason I asked is because the patient reminds me of one that we had at the Detroit General Hospital a few years ago. This was a lady, a chronic psychotic, who had been in and out of the hospital

many times. The typical pattern was that she would leave the hospital for as much as a couple of years, would subsequently return, and after another sojourn in the hospital, her condition was such that she could be released again. On this particular occasion, subsequent to her appearance at our hospital, she had been frustrated in her attempts to be readmitted to the hospital at which she had been receiving treatment. Shortly thereafter, her chronic psychosis began to re-emerge and became a little more bizarre, a little more obnoxious in form, so that the people in the house where she lived and in the neighborhood began to object, and consequently made a concerted effort to get her back to the hospital. Because of some of the conditions that prevailed at the time, she was put on a long waiting list but not readmitted to that hospital. She finally ended up, as a result of strenuous neighborhood agitation, at the Detroit General Hospital, which is our emergency psychiatric service here, and with which some of you may not be familiar. Once in the hospital, she immediately let her wishes be known to the young social worker, who unfortunately, did not pay particular attention to the patient's desire to be returned to Wayne County (her former hospital). When there was no reassurance forthcoming that she would be returned shortly, it was observed that her psychosis became progressively worse, until finally her condition assumed the proportions of the classical textbook picture of a catatonic excitement. She was also concerned that she would be forced to return home, and that she would not be kept at the state hospital. However, upon being reassured that she would be returned to Wayne County very shortly, if she could control herself in the hospital, the florid psychotic picture simply disappeared. She assured the doctor that not only could she control herself in the hospital but she was willing to go back to her room and control herself until she was returned to the Wayne County Hospital. This is exactly what happened. She was returned within about 10 days.

I think this illustrates the methods by which the former psychotic patient can utilize his psychosis. It becomes a way of organizing his life and becomes, I think, a kind of ego resource that can be resorted to, partially voluntarily, when the occasion demands. Thus, with the sophisticated, chronic psychotic patient, there is an added feature, an added resource: that which had originally been the evidence of a debacle in his life.

I was wondering, Dr. Niederland, if there may have been some element of a similar phenomenon with this patient that you mention?

DR. NIEDERLAND:

I must admit that I was unable to observe her that closely. My contact with her was maintained largely through the case worker. The one opportunity I had for strict observation was on the occasion of my intake interview with her. I would like to see her again now, but even though I am curious, I shall have to be cautious. The very fact that she must go to the chief psychiatrist of the agency can, in itself, bring on an exacerbation, and I am hesitant to interrupt the process in any way. The fact of having to appear before the chief may remind her of her forced appearances before the Nazi authorities in Germany and bring on an exacerbation.

FATHER RONALD L. HEIDELBERGER:

I wonder if it could have been something in the symbolism of the bandages themselves with which she worked—the fact that they are used for healing. I wonder also about the simplicity of the work and also the need for it. A lot of people don't care about it, but this is something she does because it is needed.

DR. NIEDERLAND:

This makes sense to me, Father Heidelberg. Red Cross work is rescue work; this is somehow known to the patient and may have mobilized restitution and rescue efforts in the patient in relation to her lost love objects (family).

QUESTION:

I am interested in knowing this woman's age, since she has apparently worked regularly.

DR. NIEDERLAND:

She is in her early forties. She was 18 or 19 when her family was taken away by the Nazis. She broke down within six months after her arrival in this country and was hospitalized for 20 years in the state hospital. She has been with us, and then with the Red Cross for a couple of years.

QUESTION:

May I ask about the relationship between patient intelligence and potential adjustment?

DR. NIEDERLAND:

This touches on the methodology of our intake process. We always go through a full psychological examination, including I.Q. testing, etc., because we have found that an average or close to average I.Q. is necessary for our type of rehabilitation work. We are an "industrial convalescence" agency, as I said, and can offer this sheltered workshop experience only for a limited time. Making one's way in life requires some intellectual capacity too, so the I.Q. does have something to do with it. On the whole, however, we rely more on the entire mental status, clinical and psychological evaluation, ego strength, and similar factors.

DR. PETTY:

I would now like to call on Father Heidelberger of the Immigration and Refugee Service, Catholic Charities, Archdiocese of Detroit.

FATHER HEIDELBERGER:

I think you know that our service does not deal with the rehabilitation directly: we are solely a resettlement service for refugees and have been in it now for 18 years. This brings us back to about 1948, and there are approximately 25,000 people throughout this area who are being helped in securing jobs, housing, furniture, and whatever else may be necessary to start them on their way.

We receive no knowledge of the background of these people, nothing about their history or what they may have suffered or endured in or outside of concentration camps or during the war. This information is not given us and we don't attempt to get it from the refugees. The basic idea is to get them started, and we don't delve into the past or talk about it unless they want to bring it up themselves. We know that, for the most part, we have had refugees from all of Europe—the Hungarians, and now the Cubans are all considered refugees; we know all of them have suffered in various degrees, so we try to treat them with that basic idea in mind.

If there is evidence of serious emotional problems, we, of course, refer them to Wayne County General or Detroit General Hospital, and we've often been anxious to know what has happened to some of them—how they have turned out and what has been done for them.

I would like to present you with a few facts about two men I have in mind whom we have dealt with rather extensively and who fit, I think, more into the pattern with which this conference is concerned.

The first case is that of a Polish man who came here in 1951, and is currently 44 years old. He is a very unusual man—always having functioned on his own, never requiring hospitalization or any kind of clinical help. He is extremely skilled in electronic work; he worked at Multi Products for four and a half years and did a marvelous job. His foreman speaks highly of him. He did excellent work, but because of his eccentricities, his inability to get along with people, the boss was forced to let him go. I'd like to cite a few of the things about this man. First of all, his attitude toward religion is 100 per cent negative: "Damn be God! The hell with God!" During his recent stay at the Detroit General Hospital for an operation, he said, "I suppose you thought I prayed?" I hadn't said a thing to him when I first saw him. He said, "I didn't pray." What's behind this? I don't know. It could be that he suffered because of religion, or he is blaming God for some of his suffering and he is not to turn to God for any help. This is buried; we don't discuss it; we don't bring it up; yet he keeps coming back to us. It is all rather mystifying—i.e., maintaining his contact with a Catholic service.

DR. NIEDERLAND:

Psychiatrically, this is a notable point. With all the rebelliousness, all the insults, etc., the patient keeps coming back. This is a positive factor. Only a patient who maintains steady contact with us can be helped. A patient who stays away holds himself out of reach of our therapeutic tools.

FATHER HEIDELBERGER:

About this matter of suspicion that was brought up yesterday, the man to whom I have been referring displays this behavior to a great

degree. He always looks at the door to see if anyone is coming. If he hears a voice, he stops talking. Sometimes the door makes a noise; he goes over to see who is there before he continues his conversation, even though he was not talking about anything confidential. He is very, very careful about who is going to hear him talk. He says, "People are always trying to find out what I say." When he goes into a telephone booth and someone passes, he stops talking. He won't have a phone in his own home because people will listen in. He would never dream of talking on a party line. We've seen this kind of behavior in other people, but it is considerably more pronounced in this man.

A little more about the man himself. He was a single fellow, who arrived here when he was around 30. He had been placed in five different rooming houses. He couldn't get along with his landlady or with other people; he was always doing all kinds of experimental work in his room in which there was a big clock and 80 milk bottles with a little milk in each one. During the night there were flashes of light at 2 o'clock in the morning, and people were wondering what was going on. Yet, he knows what he is doing; he doesn't do any damage; he has vast knowledge.

He has never spoken about his parents, his brother, or sisters. We know nothing about his family. This is something that we have not been able to get from him. He keeps saying, "Others are against me; they are jealous." He traces his having been put out of work to the jealousy of others there. He is called punchy. He has a curvature of the spine; whether this had some reaction on him, I don't know, because he was in a concentration camp, was on his way to be gassed, and escaped. It took him 10 years to bring that out. In a moment of anger he said, "They're trying to get me too. Once before they tried to kill me." This was the way it slipped out, I suppose in one of his weaker moments, because he is not inclined to tell us about himself.

Another point: the man for whom he was working at Multi Products said he misinterpreted a lot of the things that were said about him by his fellow employees. They were not trying to be mean to him, but he misinterpreted what they said. He always attached something negative to it. He said he thought others were plotting against him.

DR. NIEDERLAND:

When you spoke about his unwillingness to talk together with the factor of information slipping out against his will in a fit of anger, this is significant. It may be a manifestation of survivor guilt, of which I spoke yesterday.

FATHER HEIDELBERGER:

He has other qualities. He has never been in any trouble and is remarkably honest. Since he lost his job, he has been unable to work. He has a hernia, plus curvature of the spine, and so we've been helping him along. He is now on welfare.

Another example of the fear attitude: he is very careful about the food he eats and prepares it himself. He is very cautious about any food that is offered to him. He will not rent a place where he gets room and board; he wants to prepare his own food.

Now, at home he keeps frogs and turtles; he also raises shrimp and produces all their food—he feeds them chemically. He is truly an amazing man. When we got him back from the hospital, we visited the home right away (it was only about a week); he was touching the turtles one by one, to see if they were all right, and was seeing to their feeding.

DR. NIEDERLAND:

A psychodynamic comment: it looks to me like a restitution or rescuing effort for recovery of the lost objects, in the form of turtles, etc. He feeds the turtles and frogs in order to be a good parent to them. This is purely an assumption on my part, but it may be worth investigating further along such lines of thought. Also, the sublimation aspects of all this are worth considering and strengthening.

FATHER HEIDELBERGER:

He told us to stay away from people; they only try to bring you trouble. This is his attitude toward people.

DR. NIEDERLAND:

Human beings to him appear dangerous; however, turtles and frogs are innocent creatures.

FATHER HEIDELBERGER:

About religion: in spite of the fact that he is so adverse to it, last February 2 was a priestly day in the church, Purification of the Blessed Mother, and he didn't come—he thought we were closed that day. So, he appreciated that. Evidently, somewhere back in his life there was a religious basis; he knew about it and has never forgotten it, and it had some influence in his life.

Now, I will give you a few facts about the second man, who is 51 years old. He arrived here in 1951 from Germany, after having escaped from the Ukraine. He called upon our service only after having developed secondary anemia, which was a result of physical and mental collapse, and he was put in St. Joseph's Retreat a few years ago. We are not acquainted with his entire story. We know that he had been at Wayne County General Hospital because of his physical breakdown. He has sued the United States Government; he has a restitution case going on in all the embassies in the world practically, and is suing for sterilization as well. He alleges that he was sterilized while he was at the Wayne County General Hospital. He says it is an international crime; he is writing to our government and governmental agencies trying to get action on it. When he was at Wayne County General Hospital for a year, he obtained a three-day pass and he's been out on that three-day pass for two years—evidently they are not interested in getting him back. He operates on his own; he doesn't harm anybody. We've done everything possible; our Governor is willing to send him back, but he does not have a passport. The Russian Embassy keeps stalling and stalling. We've been supporting him for about a year now, and are going to try to get some help for him. Formerly, he would wear a cellophane bag over his head, right down to his shoulders, claiming that he was protecting himself from fallout. However, he discontinued this behavior when someone in the office said: "Well, you are not protecting you hands. What are you doing about those? If you cover your head, you'd better cover your hands too." Gradually he began to see that there was no need for the measures he had been taking in this regard. He wouldn't take the pills that were recommended by the doctor at Wayne County General because he thought there was "something wrong with them."

The conclusion I could draw from my continuous observation of

these two men through the years (with one 12 years, and the other about three years) is that with proper treatment, suspicion can be modified. Thus I would further deduce that these people have been lacking love in their lives. If this is furnished to them over a period of time they begin to see it is genuine, and begin to respond accordingly. We feel this is actually what has happened. There has been no psychiatric or psychological technical approach here; the only "therapy" has been that which I have described. Any comments or further suggestions as to what can be done for these individuals would be most welcome.

REV. BYRNE:

I had the experience of talking with my sister just after she got back from Germany in 1933, and she would talk only in whispers about things. Apparently they become so used to it, it becomes a part of them. I don't know how long this kind of behavior lasted.

DR. NIEDERLAND:

This is a common experience in all our survivors from Germany and German-occupied Europe. When they see a policeman in the streets of New York, they often go to the other side of the street. Or, when a group of soldiers march by during a parade with bayonets and rifles, they become frantic with fear. They run away or develop acute episodes of anxiety which can last for days and weeks. They may think: "The Nazis are in New York now; they have already occupied Manhattan." We try to prevent this by telling them about these events ahead of time to prepare them for it. We have to be cautious weeks before the Army Day Parade in May. We tell them that it will happen, way ahead of time; then they see to it that they will be somewhere else at the time.

S. JOSEPH FAUMAN, PH.D.:

It occurs to me that in all three cases there was a common denominator. Father Heidelberger, in discussing the last two, indicated the giving of love, but in all three it seems it couldn't be given unless the recipient could give some too. It is my feeling that herein lies the significance of the bandages, the Red Cross, the turtles, and the rest of it; it isn't possible to receive love if you cannot give it.

While I offer this not in the psychiatric sense, it simply seems to me that what needs to be thought about in regard to rehabilitation is a situation in which these kinds of relationships are possible, but not demanding. That is: concentrating on the individual rather than the situations in which he will eventually have to live if he lives outside of institutional care.

MRS. FENIG:

I was interested in the first case, in his denial of religion and the negative attitude expressed. I associated to this when Dr. Niederland was talking about survivor guilt. It was my impression, and I may be wrong, that this could be the source of his guilt feelings. This man does not want to be saved.

DR. NIEDERLAND:

Your feeling is that he does not want to be saved because his survivor guilt is so intense that he prefers not to be saved, does not merit it. I believe this is correct. You may have heard Dr. Lifton yesterday on the Hiroshima survivors. He spoke of a life-in-death existence; he even mentioned at one point that it is a form of suicide which he had observed in Japan. They lived but they cut themselves off, and the way they lived appeared to him like a form of permanent chronic suicide; they did not permit themselves to live because of ongoing survivor guilt. We encounter the same behavior in many of our concentration-camp survivors. However, in this case we do not see a denial of religion, but a rage and defiance against God which many religious survivors of persecution and disaster have to deal with. Most repress and deny it, multiplying their rituals and self-punishment in an attempt to appease God's revenge for it.

MR. GHESQUIERE:

Dr. Niederland, there are two questions I would like to ask you in regard to the comment that was made about the giving of love. Yesterday, part of the discussion was devoted to how it is necessary to develop a closing off in order to be able to work with people who have had the terrible experience of those in the concentration camps. I am wondering how these two things can be reconciled: the giving of love and the closing off process. The other thing was in regard to

the mentioned "burnt-out psychosis"—would this apply to the two cases Father Heidelberger mentioned, as it did in the first case?

DR. NIEDERLAND:

I shall address myself to the second question first because it is simpler to answer. The term "burnt-out psychosis" is psychiatric slang to denote the changes in the ego and personality left after chronic psychosis, a state which is usually free of delusions, hallucinations, and tendency to violence. We have seen, clinically, that in the process of psychosis, the patient will arrive at a state where the acute symptoms subside, though sometimes only incompletely. Here then, Father Heidelberger's cases do not quite meet the criteria of true "burnt-out psychosis." If these patients are still in the condition he describes, their psychosis may show signs of burning out, but he tells us that the man still has to protect himself with a helmet of plastic, and the like.

I consider the first question to be important because it relates not only to clinical matters, but to human beings in general. Dynamically speaking, the capacity to love—to receive love as well as to give love—resides in the ego. In other words, as we see it, there must be a more or less intact area in the ego organization, and it is through the intact segment of the ego that love can be received as well as given.

REV. BYRNE:

I would like to comment on the attitude against religion. I think that the more one expects this negativism, the more comfortable the patient will be, and in time it will not mean much. If one encourages it by arguing with him, nothing will be accomplished. The very fact that the patient recognized the Feast Day, I think, is truly significant, but one shouldn't jump to conclusions; one should just respect the fact.

The other thing I want to comment on is the International Institute. I'm not on the staff, but my wife is, in Detroit. I think this is really a therapeutic community because so many of the people there have been through these same experiences and they can talk about them over and over again, trying to master their experiences. It does help them by being able to talk in this kind of protective environment.

MR. GHESQUIERE:

Dr. Niederland, you referred to the ego organization being attacked by the exposure to traumatic data. In the closing off process, which takes place in the relationship with the traumatized individual, what is the process by which the therapist can remain sensitive to the emotional experiences of the person he is interviewing and, at the same time, protect himself from the pressing involvement which is likely to occur?

DR. NIEDERLAND:

As I see it, the closing off process (or psychological closure) occurs at the height of the massive traumatization, sometimes within seconds or minutes, when the person saw before his very own eyes close family members, his friends, his children, being taken away to the gas chambers, etc. They defended themselves by such psychological closing off and ceased to feel. The closing off mechanism of defense goes beyond the known defenses of denial and repression. What takes place dynamically under the impact of the ongoing rehabilitation process, as Father Heidelberger described it, or as we try to do it in our social-psychiatric teamwork at Altro, is approximately the opposite: the closed off area begins to open up gradually, almost piecemeal. After some years he has begun to develop some trust; he can literally open up what had been psychologically closed off, which is almost tantamount to bodily closure (he had sealed off his body to the dangers from without). As to the therapist's closing off, it is defensive and does nothing to help the ability for empathy and intuition, but it usually takes place under the impact of strong stimulus anyway, where great sensitivity is not a virtue.

MR. GHESQUIERE:

I was referring to the closing off on the part of the interviewer, also protectively. How can you maintain the empathy and do what you should be doing when you are closed off?

DR. NIEDERLAND:

I am not able fully to answer, because as an analyst I have been analyzed and can deal with it through ongoing self-analysis; in fact,

I have to deal with it by trying to discover all personal reactions, feelings and associations during daily analytic work. I deal with my own closing off tendencies, if any, through continued analysis. I can only say that discovering what one is reacting to is personally helpful, and gives a clue to what the patient is expressing as well.

MR. SAM LERNER:

As you know, the Jewish Family and Children's Service has been involved for many years in much the same kind of work that Father Heidelberger talked about, in terms of the resettlement of refugees in this country. Many of these people come to our attention, obviously, in the initial stage of resettlement. This has been going on for many years. We had a large influx, as you know, right after the war. Before the war, we had a large number of clients who had not themselves been in camps, but whose friends and relatives had been killed. Thus their experiences were essentially similar to those of the concentration-camp survivors. Now, we are getting a new group of people, some of whom remained in Europe for one reason or another, and who are now coming from behind the Iron Curtain, many from Poland. Some may have been through the camps and some not; nevertheless they have experienced various kinds of persecutory experiences.

Our program consists of a general process of rehabilitation similar to Altro, but on a much smaller scale. That is, our initial process involves trying to provide housing, food, jobs, and physical rehabilitation. There is a Jewish Vocational Service which offers vocational aptitude tests, as well as a sheltered workshop for the few who cannot work out in the community. In other words, our program applies not only to the postpsychotic after hospitalization, but is also designed for those who, although never reaching that stage, are nonetheless unable to adjust adequately to the community in a regular work situation. We are also getting a group of these individuals who, in a sense, have missed their adolescence; they have been denied a very significant stage in their lives—they married shortly after the concentration-camp experience and are now raising their own children. We find among these people a tremendous number of disturbed marital relationships and disturbed parent-child relationships, particularly as the children grow older and arrive at stages which the parents themselves never really had an opportunity to live through;

consequently they don't know quite how to handle them. This has resulted in very distorted parent-child relationships, and disturbances in the children—a continuous process. In an attempt to assert independence, many of these people would not accept casework treatment or any kind of treatment, for that matter, at the time that they came, other than the immediate help and adjustment in getting a job. In some cases, however, there is a desire to be dependent. It is only now, many years after their liberation that we are getting them as a result of the emotional problems that are showing up and which they still resist significantly. Very often they are referrals from the school system or from a physician; to a lesser degree, they come self-referred. Whatever images they may have of the agency and of authority figures, these past images that they had probably figure highly in their reluctance and difficulty in getting involved in a treatment type of relationship.

One case is related to many of the problems that we have been talking about for the past two days. It concerns a man who came here in the late thirties, whose father and brother were killed in the camps and who had gone through a number of traumatic experiences. We knew practically nothing about him and he would tell us just about nothing. Years later, we found out that his mother was still in the picture. He may not have known about it, although we speculate that he probably did. He was hospitalized in the Ypsilanti State Hospital from 1949 to 1957 and was released only when his mother came for him and he was allowed to visit with her. She remained in Detroit for a very short time and then decided to go on to South America where some of her other relatives lived. The patient has managed to get along outside the hospital since that time, largely through the supportive help of our agency. We had to help him deal with his reaction to the loss of a mother who left him yet again to go visit her other relatives in South America.

According to the worker's summary report, this patient used her as a mother-figure throughout these years, and accepted guidance from her even through his most paranoid period. This is an indication of how, in a sense, these was a restitution effort, through the worker, to find another mother. The worker has done a good supportive job throughout the years. She has told us that during the last three years, the relationship has stabilized and improved. He now keeps house for himself in a very decent hotel room. He spends his

time in public libraries, attends concerts, free films, exhibitions, etc. He has also been attending some activities at the Jewish Community Center, such as dramatic groups. He is totally unable to involve himself in any kind of employment. He is fearful of close contact with people and is extremely afraid of being returned to the State Hospital. This has created a serious problem in terms of the indemnification process, because he refuses to sign any statements or documents for fear that he will be "caught" in some way. We are in a quandary as to what extent we should assume guardianship. We've been given some supportive help, but nevertheless much of this money has been coming from the mother, who has been sending regular stipends to him through us. She anticipates the end of her life soon, and the problem is: what are the long-term prospects for this kind of an individual? Should one attempt to obtain guardianship without consent? This may be legally possible, as we were told by one of the Probate Judges. To what extent should one participate in the process and stir up all the fears and anxieties that are involved? I am posing this not only in terms of a question, but really as an illustration of the complexity, the long-term efforts involved in working with these kind of paranoid, postpsychotic individuals.

DR. NIEDERLAND:

This is an impressive and graphic description of the difficulties we run into almost routinely in our most severely disturbed ongoing psychiatric patients. Permits me to compare Mr. Lerner's description with an unfortunate experience I had just a few weeks ago at Altro: I saw a patient on the last day of 1964. The patient had been hospitalized repeatedly and had been released from the State Hospital after a short hospitalization, still with recurrent symptomatology involving persecution ideas, i.e., acute fear of policemen, complete withdrawal, isolation, no friends, living alone in a furnished room. He was the only survivor of a family group of some 50 or 60 people—a survivor of Auschwitz. After years of contact, in spite of the ongoing symptomatology, we thought we could help him through rehabilitation work in the workshop, but were unsuccessful. Sad as it is, I must also pursue the negative experiences; we cannot permit ourselves to be misled by our own enthusiasm or therapeutic ambitions. I believe we came with our help too early, as the report will show you. I saw him in our intake department and he impressed

me as a man, even phenomenologically, who looked as if he carried the whole world of aches and pains and weight on his shoulders. We knew the history of the 60-member family loss. He was a powerfully built man in his forties; a stocky, heavy-set individual with broad and stooped shoulders. Though in a stooped posture, he walked and talked freely at first; very soon, after a few friendly and benevolent exchanges, the patient went into an acute paranoid episode right before my eyes, and expressed, at first in a whispering voice and then loudly, his fears of being killed right there (where he was being interviewed) and of having an autopsy performed on him first there and then in the Altro workshop. He was not only extremely anxious and fearful, but appeared to be fully convinced that this was going to happen to him. When I asked him why this would happen, he repeated again and again his conviction that the persecutory measures mentioned (being killed, with an autopsy following) would be taken against him. He pleaded for forgiveness and even went down on his knees begging and pleading: "Don't kill me, don't kill me." He behaved as if he were about to be taken to a slaughter house or to execution. It became apparent that his acute paranoid fears were connected with the persecution experiences he underwent during childhood—being taken to a concentration camp at the age of 14. He mentioned almost nothing about it. I tried to get him to talk about this and, on repeated questioning, he finally mentioned the name of one concentration camp in which he had been—Flossen-burg. I believe this is one of the camps where "experiments" were performed on the prisoners, and very few survived that camp. He says he does not remember anything about it. He said only that he was there—nothing else. It is possible that his whole family was killed on the way to Flossen-burg, or in Flossen-burg itself, and that he is the only survivor. The patient had to be rehospitized later.

Going back, you may remember that often work itself is perceived as a coercion; in this instance, even though it was handled in a kind and understanding way, it didn't help. The very fact that this patient had come to the psychiatrist for intake into a workshop apparently produced in him an acute paranoid panic reaction.

Summary

The utilization of ancillary services in the rehabilitation of the regressed and emotionally incapacitated survivors poses some special

problems. The use of workshops for occupational therapy allows the development of certain transference in which the occupational therapist, shop manager and fellow patients may be identified with various figures from the past. Since it is very stressful for a shop director to be treated and experienced as a Nazi, or Capo, or for an occupational therapist to be similarly accused, special preparation of the staff becomes necessary. A variety of other rehabilitation measures run into difficulties similarly derived: the vocational retraining may stimulate preconscious phantasies within the survivor related to the proposed occupation in relationship to the survival value or guilt-complication in the frame of reference of the Nazi persecution. To be a barber, for instance, might be an overvalued occupation, "because one is allowed to stay in the barrack and not go out on the commando"; or it may be posing a homosexual threat in terms of the same meaning, as the barbers were sometimes the homosexual lovers of the Block Aeltester. Similarly, physical therapy may either stimulate intense passive yearnings, which might threaten the patient's all-consuming struggle against them, or may be experienced as a physical attack, rape, even a cannibalistic approach, in the sense of special interest of the therapist in the patient's skin or bones, etc.

The point is, that for the survivors of massive trauma, the memory of this event, all of its implications and unconscious phantasies and striving which became linked by association become the dominant force in determining their life style, existence, and way of perceiving and interpreting everything about them. For instance, Jewish survivors of Nazi persecution upon entering a room often think and even comment, that this or that area would make an excellent hiding place.

When the rehabilitation staff is aware of the problems of the trauma-connected transferences, they are able to avoid being upset by them, and to the extent permissible by the patient's condition and his own abilities, they can be helpful to the patient by making these reactions and their source conscious. If the religious workers, in the above-described case of the man who cursed God, had known about the survivors' problem of aggression, they could have been of much greater help to the patient.

Because of the severe ambivalence and fear of their aggression, the massively traumatized patients have to split up their transference, so that at any one moment, one member of the rehabilitation team

may represent the bad object, while another will be the yearned-for comforting mother; yet another will be the seductive, provocative, primitive one, and so on. For those patients who are in psychotherapeutic treatment, it is essential that all those "dispersed" transferences be reported to the therapist and that both the splitting and the types of transference split off be dealt with as though these were all acted out towards the therapist (Krystal, 1964). For the rest, at least these problems have to be dealt with, as simply as possible.

The process of rehabilitation of a massively traumatized individual has much in common with rehabilitation after an illness or injury which involves an irreparable loss of limb or function. What these areas have in common is the reaction to a loss so great that it threatens to disorganize the individual's psychic function. For this reason, we have discussed the psychological complications of convalescence, all of which in the last analysis represent ways in which the reaction to the loss can "go wrong" and produce a psychiatric disturbance, rather than lead to a "working through" and complete readjustment. Survivors of a massive assault, such as genocide, natural, or man-made disasters, find themselves confronted with so many losses and dislocations at once, that they are not able to work through these losses and master them. The mere quantity of grief and pain is such that could it not be handled by repression, denial, "psychic closure," or the like, it would overwhelm one. The "survivors" develop a chronic state of pathological mourning and depression. Under these circumstances no loss, especially no loss of a love object, one's limb, or function, can be dealt with in the normal way, because it revives the "unfinished business" of grieving for the original losses and thus becomes the threat of new trauma.

In addition, for people burdened with survivor guilt, every misfortune is experienced as punishment, thus reviving and intensifying the problems of depression and anxiety. Finally, and this phenomenon may be specific to concentration-camp survivors, the hypochondriasis resulting from the worry as to whether one's physical condition will allow one to "pass" the next selection, and the various other reactions related to starvation (or in the case of Hiroshima survivors the "mystery" of radiation disease), all cause a highly ambivalent hypercathexis of one's organs. Under these circumstances, the loss of it may result in a paranoid affect storm and various other sequences, as in the case of a woman who had a partial gastrectomy, thinly veiled

cannibalistic ideas, and a fear of being poisoned. This was traced to the fact that she felt guilty for those who had starved to death all around her, because she had survived by virtue of having worked in a kitchen, her alimentary tract was experienced as indispensable for her survival. Thus the discovery of the specific details of a traumatized individual's experience and the unconscious phantasies which became attached to it, is our means of preventing and dealing with the abnormal reactions to illness and injury in massively traumatized individuals.

Related to the subject of object-loss is the yearning (hope) that the lost people be restored magically. The most common expectation is that such love objects would return in the form of children. This accounts for the early marriages of survivors, "because I didn't have anybody." In such situations, the children represent the new versions of parents, close relatives, or offspring lost in the holocaust. Therefore, when a survivor's child suffers an illness or injury, the parent has to deal with the revival of all of his psychological reactions which had remained repressed up to the time of this new misfortune.

The question of social rehabilitation is one in which specific diagnosis and specific treatment measures will have to evolve. We find that the survivors of Nazi persecution who had a decade of fairly secure family and community life prior to the holocaust, have shown little difficulty in assuming stable and reliable work and family patterns. Thus, we do not have to deal with problems of employment, antisocial behavior, child neglect, or failure in the formation of a cohesive family. This is in contrast to the problem of rehabilitation of the urban poverty and slum cultures, in which no stable patterns for work, mothering, or responsibility were available for the child. The survivors of a massive destructive assault, on the other hand, suffer from social pathology related to the distrust and fear of man. Their basic trust in the beneficence of God, reasonable behavior of man, and causality in general has been destroyed.

This trust is an essential ingredient in that minimum of optimistic faith in the future, without which men are not able to plan effectively and live in constant worry and apprehension. The destruction of the feeling of men's basic goodness (a feeling which is a residue of a fairly satisfactory childhood) places the survivor in a world of chaos and danger. He suspects everyone and trusts no one, including himself. This type of problem may be difficult to treat or modify.

Aggression can be nursed for long periods and when externalized by a group leads to strife and war. Since aggression in groups of nations has hitherto escaped man's control, it may be wise to concentrate on dealing with it in individuals who had been subjected to such traumata as defeat, uprooting, or war. It cannot be said that adequate care is given to refugees, survivors of disaster, releasees from prison, internment camps, or chronic hospitals, unless a rehabilitation team is available to them for dealing with the psychological and sociological aftereffects of the injurious event.

X. Clinical Observations on the Survivor Syndrome

H. KRYSTAL, M.D., AND W. G. NIEDERLAND, M.D.:

Our experiences over the last 20 years, in the diagnosis and treatment of concentration- and extermination-camp survivors, indicates that we are dealing here with victims of a traumatization of such magnitude, severity, and duration as to produce a recognizable clinical syndrome. This view has been documented amply in the present volume, and received support from others who have worked in this area. We have learned to recognize a syndrome characterized by the persistence of symptoms of withdrawal from social life, insomnia, nightmares, chronic depressive and anxiety reaction, and far-reaching somatization.

In order to study this clinical picture in detail, and perhaps test reliability of the correlations between the patient's history and present symptoms, we have selected at random 149 case records and examined them statistically. The patients' records were obtained by one or more psychiatric examinations, mostly consisting of anamnesis, review of present symptoms, as well as their development and function since liberation. A special effort was made to obtain a pre-persecution history, both developmental and familial, as well as educational and industrial. We traced the persecutions in detail, trying to identify the exact nature of the traumatic events, and their possible correlation to the post-liberation syndrome. We paid special attention to the patients' reactions to loss of love objects, property, and position, as well as individual characteristics and aspects such as religion, national identity, and other attachments which would be affected by uprooting. The authors have (separately and jointly) reported on the nature of the defenses employed under the persecutions, together with the aftermath events (see Chapters II and III).

By way of summary of the previous proceedings, we shall review the information from 149 charts pertaining to the symptoms, the ages of the patients, the industrial status and its changes, history of loss of relatives, and other objects and reactions corresponding to these conditions. The information was then coded and computed electronically. From this data, we have obtained the following clinical picture.

THE SURVIVOR SYNDROME

A. Anxiety

Predominant among the chronic complaints of the patients were anxiety, as well as the components and equivalents of this affect. Anxiety was the major complaint in 142 cases, i.e., 97 per cent of this population. Within this group, the nature of the complaints varied in one or more of the following ways: chronic tendency to worry, found in 39 per cent of subjects; vigilance and multiple phobias, 77 per cent; diffuse fears about renewed persecutions, 31 per cent; and a general "expectation of catastrophe," 24 per cent.

The fears of concentration-camp survivors have three relevant clinical characteristics:

- 1) The patients are commonly troubled with fears about something terrible happening to their mates or children when out of sight (31 per cent).
- 2) The fears are of intensified current situations and uncertainties which reawaken in the victims echoes or images of the terrors experienced (e.g., Eichmann trial, medical examinations).
- 3) Persistent, and in many cases apparently irreversible, fears of certain people whose sight, appearance, or behavior reminds the survivor of similar people (or their behavior) in the persecution situation, e.g., uniformed policemen, marching columns of soldiers, inquisitive behavior of doctors or officials, etc.

B. Sleep Disturbances

All of our patients reported some sleep difficulties, mostly varieties of insomnia. Also very common were anxiety dreams and nightmares, reported by 106 patients (71 per cent). Of these, 61 patients (41 per

cent) had severe nightmares. As has been previously pointed out by Dr. Tanay in this volume, these nightmares are "reruns" of persecutions, with hardly any modification, a fact which can be considered part of the disturbances of cognition.

The awakening from the nightmare is often a slow and painful process; many patients appear to remain in a confused, sometimes stuporous state on awakening. Any physical discomfort or anxiety can bring on these dreams. Thus, the memory of the persecution and trauma seems to have become a dream-screen and memory-screen which can be evoked by any danger, anxiety, or discomfort, past and present.

C. Disturbances of Cognition and Memory

Many patients were aware of some degree of disturbance in cognition at some point subsequent to liberation. Almost ubiquitous were disturbances of memory. Many memories of persecution have become hypermnesic, at the same time occurring with such clarity and being so threatening that the patient cannot be sure that the old horrors have not, in fact, reappeared. The persistence of such hypermnesic, affectively charged, and in many cases indelible memories—imprints or engrams—seems to point to an inadequacy of the ego's usual repression mechanism in dealing with traumatic events of such magnitude. On the other hand, we also observed far-reaching memory defects with total or partial amnesia for various traumatic events, marked vagueness of the capacity to recollect, and the emergence of acute episodes of confusion and anxiety when urged (e.g., by the examining physician) to remember what the events were. Under such conditions, nonpsychotic patients may experience anxiety of an intensity that threatens their orientation in time and place, and may become acutely confused. In the most intense panics, we observed episodes of confusion, disorientation, and also dreamlike states in which the patients believed themselves to be back in a concentration camp (7 per cent of our patients).

Such phenomena were even more common as a continuation of the above-mentioned nightmares. Four per cent of the patients volunteered the observation that, at times, their nightmares would "continue upon waking." Dreams pass into hallucinations and delusions with greater frequency than is observable in the normal population.

The persecution dreams will frequently have one (frightening) modification from the actual experience—children who were not yet born at the time of the Nazi persecutions are now included. This observation is dynamically related to the next disturbance of cognition: the patients have continuous obsessions about injury to their children and mates, and are anxious about them whenever they are out of sight.

The final tally of disturbances of cognition, with their overlapping incidence, follows:

DISTURBANCES OF COGNITION

Degree and Type	Cases	% of Population
1. No disturbances of cognition	98	66%
2. Confusion of past and present under sway of fears or dreams	12	8%
3. Hypermnnesia	12	8%
4. Amnesia alone or with other disturbances of memory	26	19%
5. Disturbances of orientation: "lost and bewildered"	10	7%
6. Dreams merging into hallucinations	6	4%
7. Daytime "dreamlike experiences" in waking state	4	3%

Alterations of identity and self-identity (persistent feelings of being "different" from others and/or from one's previous self), feelings of "otherness," being a completely different person or being of a different species, character, etc.; to this group belong also the states which the Germans (see Venzlaff) call "*Persönlichkeitswandel*," i.e., a lasting change of the total personality in all its relations to the world "within" (to one's own self) as well as to the world "without" (society, interpersonal relations, etc.).

D. The Chronic Depressive Manifestations

The chronic depressive manifestations include a wide spectrum of clinical phenomena. The most persistent, practically universal finding in the area of lasting personality disturbances is the establishment of a masochistic character trait disturbance (118 cases, 79 per

cent of total). This figure, when compared to the high incidence of survivor guilt (151 cases, or 92 per cent) shows the pathogenic effect of such guilt. Survivor guilt was especially strongly correlated to the loss of children, both in incidence and severity ($\chi^2 = 54.30$; $f = 26$, reliable at the .001 level). The loss of an only child, or loss of all children in cases where no children were born after liberation, produced the most severe depressions, with several psychotic depressions occurring in this group. The following correlations was observed: masochistic character traits were found in 20 out of 23 patients who lost their mates in the persecution (88 per cent, $\chi^2 = 34.85$; $f = 16$, significant at the .01 level).

Of the 29 patients who lost one or more children in the Nazi persecutions, masochistic character traits were noted in 25 cases (86 per cent, $\chi^2 = 21.21$; $f = 14$, significant at the 0.1 level). When reviewed in relation to the loss of *any* relative, 118 of 127 patients were found to be masochistic (79 per cent, $\chi^2 = 27.20$; $f = 16$, significant at the .05 level). Of the 115 individuals who lost no relatives in the most immediate family, only 51 (39 per cent) showed masochistic traits.

It is our impression that next to, probably in conjunction with, the alteration of character and personality, masochism with or without concomitant clinical features of depression is the most common aftereffect of persecution and is closely related to survivor guilt. Of our patients, 92 per cent expressed self-reproach for failing to save their relatives, and 14 patients (9 per cent) expressed the wish that they had been killed instead of their relatives. An additional group acted out such wishes in conversion symptoms, e.g. fainting, paralysis, or in the style of their lives, i.e. character neuroses.

1. Industrial Function and Depression. In warding off overt depression, some men tend to be hyperactive, or "addicted to overworking." Such activities sometimes can be recognized as hypomanic defenses against depression. Sometimes the need to work hard to avoid confrontation with depressive material runs contrary to the chronic physical deficiencies of which the patients suffer. Thus, of 92 men, 74 or 82 per cent had some industrial handicap, and of these, eight had a history of overworking and driving themselves to periodic exhaustion (9 per cent of all men).

The women tend to center their masochism around their family

lives. Sterility and history of miscarriage of first (postwar) pregnancy appear to be relatively high, as is the incidence of hysterectomies. The martyrlike prostration of the women in their family lives toward their husband, children, and adversity are quite conspicuous. Of the women in this series, only 2 per cent were considered completely successful in their function as wives and mothers, and 45 (49 per cent) of all women were considered grossly inadequate as housekeepers and mothers.

A practically universal finding among "survivors" is their masochistically tinged tendency toward suffering and expiation, and their inability to enjoy anything in their lives. Most had no use for the word "fun" in their vocabulary. In fact, many of our patients were not only unable to afford themselves some of the most innocent types of pleasure (e.g., visiting a movie, concert, or social participation with others) but even considered it outright immoral that they should enjoy themselves when most of their families had been killed.

2. *Clinical Syndromes of Depression.* The varieties of depressive syndromes were most conspicuous among the subjects:

Only 30 patients (20%) did not *complain* of depression

14 patients (9%) suffered from crying spells

67 patients (45%) suffered from periods of depression

31 patients (20%) had agitated depressions

7 patients (6%) had severe or psychotic depressions
requiring hospitalization

As to the type of depression and the psychological mechanisms involved, one of the authors (Niederland) observed in most of his patients shocklike experiences and strong fixations to a feeling of *helplessness*. Bibring (1953), as is known, regards depression as a basic ego-phenomenon and as a reaction to situations of intense narcissistic frustration which the ego is unable to prevent. We also agree with Jacobson (1954), who despite extended observation, has found it difficult to draw an exact distinction between "neurotic" and "psychotic" depressions. Many of our patients exhibit clinical features of borderline pathology with ego and superego impairment, precarious object relations, and severely disturbed affectivity far beyond that encountered in neurotic patients. For instance, we found paranoid features in 13 per cent of all cases, and significant

disturbance of affectivity, ranging all the way to outright schizoid isolation in 72 per cent of all patients.

Special attention has to be given to three aspects of depressions: (1) its relationship to anxiety; (2) the utilization of projection or paranoid mechanisms; and (3) the extent of danger of suicide.

As a general rule, it may be said that depression in concentration-camp survivors tends to be of an agitated type, i.e., associated with anxiety. Looked at another way, one might say that the defensive operation of psychomotor retardation is rarely successful in these individuals. The truly retarded depressed patients were found only 33 times, or in 22 per cent of all patients.

This observation goes along with our hypothesis that the major pathogenic force is survivor guilt. Because of regression, partial identification with the aggressor, and the inability to repress or master the memories of sadistic assaults upon themselves and their love objects, the patients have a tendency to visualize physical torture and therefore cannot take their depressions resignedly.

The association of anxiety or agitation with depression occurred in 75 cases, or 53 per cent of our population. One of us (Niederland, 1964) pointed out, and we alluded to this in our discussion of the dreams of concentration-camp survivors, that the patients have a tendency to confuse the present with the past. This is part of an impairment of the ego-function of reality testing and integration, or consciously owning up to one's mental material. Such a defect, if severe and inaccessible to correction, may lead to psychotic depression or the appearance of delusional or hallucinatory experiences.

The patients tend to hallucinate, especially at night when they cannot ward off their anxiety by activity or distracting themselves. A couple who were depressed and infantile but not psychotic during the day, regularly hallucinated at night. The wife experienced terror of S.S. men and dogs threatening their house, and pleaded with her husband to chase them away. There is also the possibility that the sensory deprivation occurring normally at night favors the stimulation of hallucinations. One of the patients mentioned above had, in fact, been attacked by an S.S. man and bitten by his dog. The assault resulted in a partial hearing loss. In her regressed state, the patient developed almost total psychogenic deafness in addition to the organic deficit. Although usually quite unable to hear, once

she formed a transference to one of the authors (HK) she heard quite well.

The above example illustrates in a rather severe way the general tendency in the handling of the depressions; namely, that the frequency of agitated and paranoid symptoms is relatively high. On the other hand, in proportion to the depressions, suicide attempts were few. Even considering the total number of concentration-camp survivors we have seen over the last 20 years, amounting to several hundred patients, there were only a dozen suicide attempts and only one known successful suicide. Much greater is the danger of precipitating a full-blown "psychotic" depression, possibly with paranoid symptoms, by gratifications or wish fulfillments. Any such gratification which may, in the patient's mind, be experienced as benefiting from the destruction of the lost families is especially threatening to his homeostasis.

E. Object Relations and Schizoid Defenses

The general impression in this group is that of greatly impoverished object relationship, with great ambivalence. General rigidity, withdrawal, infantile relationships, and even schizoid withdrawal were observed. Survivors show a high incidence of abnormal object-relations which could be arbitrarily classified as follows:

1. 21% of the patients related some disturbance of affectivity in relation to their closest objects.
2. 27 (18%) stated that they could not relate warmly to anyone.
3. 19 patients (13%) had few friends.
4. 27 patients (18%) had no friends.
5. 13 patients (9%) could be considered complete schizoid social isolates.

Many of the marriages were entered as an attempt to reconstruct the lost families and deny the destruction of the relatives, and have ended up in a hostile "stalemate." While our patients cannot express their aggression freely because of a fear of it, their children "explode" with it in aggressive behavior upon reaching adolescence.

A ramification of survivor guilt, is the fear of finding new love, which many patients regard as an expression of "infidelity" to the martyrs. Others avoid new cathectic investments for fear that they will again lose their love objects and suffer the pain all over again. Pertinent here are recent clinical observations that physical pain

may be associated with, accompany, or act as an equivalent for depression (Bradley, 1963), a fact known, of course, to many clinicians for years.

F. Ego Integrity in Regard to Reality Testing and Predisposition to Mental Illness

In a number of our patients, we discovered transient or long-lasting psychiatric states, represented by impairment of reality testing, accompanied by a temporary overwhelming of the patient with hallucinations or dreaded events, fantasies of revenge, reunion and identification with dead relatives, and projection of ideas. We have observed periods of mutism, withdrawal, and immobility in reaction to a current loss or anniversary of Nazi murders. Yet, considering the nature and extent of the events of the past, it would be less accurate to say that this type of patient has a constitutionally determined schizophrenia, than to say that he grew up in a psychotic world, a world which has gone berserk, and that he is therefore reacting appropriately to a chaotic and eerie reality, which in many ways showed a close affinity to the world destruction fantasies of many psychotic individuals. The only genuine disturbance of reality testing these patients show is that they still react as though they were in the hands of the Nazis during the Nazi regime. For in the Hitler era, when the Jews were vanquished, isolated in small ghettos, terrorized, starved, infested with dirt and lice, humiliated and hopeless, when they came to learn that extermination was near and inevitable, catatonic submission to fate was no more psychotic than the paranoid, hebephrenic, and catatonically excited behavior displayed by their drunken, thieving, raping, and murdering persecutors.

In fact, in the group of 149 we found only eight cases which had a family or pre-persecution personal history of gross emotional problems (5.3 per cent). In 109 cases, or 79 per cent, familial hereditary taint and personal predisposition were ruled out positively, and in the remaining cases no history was available. There was one person with a pre-persecution schizophrenic history. This was a case of an autistic child, the product of a mixed marriage, whose problem was one of disturbed identity attributed in part to a father-turned-Nazi situation. She had not been in any ghetto or concentration camp, which in all probability she could not have survived.

However, in the group with a history of some pre-persecution emotional problems, postwar severe mental illness was more common; e.g., depression with paranoid features occurred in 25 per cent of these cases, compared to 3.3 per cent for the whole group ($\chi^2 = 25.32$; $f = 8$, reliable at the .001 level). They also show a greater change in religious beliefs: i.e., a lesser stability in maintaining their faith; 12 per cent of them lost their faith during the process of persecution, compared to 2.6 per cent for the total group ($\chi^2 = 168.12$; $f = 24$, reliable at the .001 level). But, whereas the general group included some who became more religious, especially ritualistically so, there were none who became more ardent in their religion in the group who had a personal or family history of mental illness.

G. Psychosomatic Disease

When we discuss the problem of predisposition, psychosomatic disease comes up for consideration, for we have such an extremely high rate of somatization that one must wonder whether a selection of a certain *type* of patient was not a factor in this incidence. Whereas people with schizophrenic or self-destructive tendencies were very quickly killed in the ghettos and concentration camps, selectively, the hyperalert and exceedingly pliable and adjustable individuals apparently had a better chance of survival.

One must wonder whether, besides their psychological capacity for adjustments necessary for survival, these people did not have a characteristic physiological makeup which made them act extremely effectively and withstand much under severe stress. This former asset now may be related to the high rate of certain psychosomatic illnesses which are, in fact, also symptoms of chronic stress and anxiety pictures.

Somatization of anxiety and aggression is, of course, granted, and especially so among survivors who were in the camps in the second and third decades of their lives, but not infrequently in other age groups as well.¹

¹A 15-year follow-up on shell-shocked soldiers of the American Army showed a similar persistence of "jumpiness" and startle reactions as the most common symptom found in over 95 per cent of the patients. Many other symptoms found were also identical with those of the concentration-camp survivors (Archibald, 1962), suggesting a common syndrome of late sequelae of massive psychic trauma; hence, the clinical picture presented here has wide implications in psychiatry.

In the group of patients who were 15-30 years old during the persecution, the incidence of psychosomatic disease was 55-60 per cent as compared to 30 per cent for the whole group. The reactions seem to be especially related to the experience of overwhelming rage and despair under complete passivity. The somatic symptoms are less frequent, severe, or conspicuous in survivors who had been able to become active in the matter of their survival and who therefore could fight their enemies. These survivors who had been more active suffer from depressive problems, but not from the psychophysiological disturbances. Apparently, passivity and especially arrest in motility, as in long periods of hiding in limited space, led to greater somatization of anxiety and tension.

The most frequent psychosomatic or psychophysiologic problems can be organized along the following lines:

1. Problems directly related to muscle tension.

In this group, we start with the observations that many survivors show an excessive tenseness and hyper-reactivity to minor stimuli (39 patients or 26 per cent of the present series). They tend to show persistent startle reactions and are in a state of "at-tension" (70 patients, 49 per cent of total). The tension is apparent as a character trait too, as intensity, hyperalertness and hyper-reactivity (Weiss, 1959).

It is the author's impression that the chronic increase in muscle tension results in a chronic feeling of tiredness and exhaustion. The survivors often complain of an inability to fall asleep because of the subjective feeling of "busy legs" (16 cases, 11 per cent). This represents a state of tension in which the patient cannot relax, and one of low-grade pain. The transition into the next group of symptoms related to pains and aches in muscles and joints is very gradual.

2. Syndromes of pain resulting from increased muscle tension.

Total incidence in this group was 102 cases or 81 per cent.

- a) The increased muscle tension first manifests itself in feelings of "tiredness" or subliminal pain in muscles and joints (47 cases, 31 per cent).
- b) The pain in muscles and joints may become aggravated by increased emotional tension, changes in barometric pressure and other weather changes, and finally may become precipi-

tated by any physical illness (reported in 79 cases, or 53 per cent of our population).

- c) Syndromes of "exhaustion" which become physical crises secondary to the chronic muscle tension (9 per cent). Some have additional meanings such as depression equivalents or panic secondary to failure in obtaining relief from drugs.
- d) Arthriticlike "attacks." In 46 of our patients (31 per cent) the muscle and joint pains came in arthriticlike spells. The myalgia and the arthralgia were rarely accompanied by heat or swelling and left no evidence of physical damage. Thus, they could be classified as Pallindromic rheumatism but were a psychosomatic type of arthritis (Cain, 1944; Mazer, 1942; Paul and Logan, 1943; Kinzer, 1953).

3. Syndromes of headaches.

The survivors of concentration camps suffer from headaches practically without exception. There are at least three types of headaches noticeable in these survivors which cannot always be clearly distinguished:

- a) Tension headaches. These headaches often start from the neck, masseter, or temporal muscles, but eventually radiate to the whole head (44 cases, 29 per cent).
- b) Migraine headaches and equivalents. Pain and throbbing in temples, nausea, vomiting, and scotomata are most common (38 cases, 25 per cent).
- c) Headaches of a "special survivor type." We do not know whether these headaches cannot be found in other people, but they are very characteristic in the survivors. They are described as a "stabbing" kind, as "though the head was going to break." They are disabling, steady, sometimes start at the base of the skull or forehead, and may sometimes resemble histamine headaches subjectively. There is no throbbing or blood pressure disturbance. These were reported in all our cases. The writings of Norwegian and Danish workers (Strom, 1961), especially Eitinger (1947, 1961, 1963), suggest that these headaches may be related to direct brain damage, perhaps secondary to changes associated with chronic starvation rather than blows to the head.

4. Allergiclike symptoms.

Reported in 13 cases (9 per cent). Sometimes arthritic or headache symptoms may be preceded by either allergic or histaminelike symptoms, such as itching or burning of the nose and "snout" area, burning of eyes, or diffuse itching or eruption of the skin. One of the authors (Niederland) repeatedly observed cases of chronic rhinitis which were laryngologically diagnosed as allergic or vasomotoric rhinitis.

At other times, the early symptoms resemble hepatitislike syndromes, beginning with a distaste for cigarettes and, at times, showing actual hepatic disturbances. This is especially true of concentration-camp survivors who have mild cirrhosis of the liver. Although this has only been proven in a small number of cases, we feel, in view of the great reserve of the liver, that some liver damage secondary to chronic starvation is very common, if not universal, in concentration-camp survivors.

5. Anxiety equivalents.

"Autonomic system dystonia" or "neurovegetative dystonia" is a term very dear to the hearts of European psychiatrists on the assumption that the autonomic nervous system is subject to unbalance when either the sympathetic or parasympathetic system become overactive. Meerloo (1963a) speaks of this as an example of neurologism and denial of the emotional problems. The term is as inadequate as "lacrimal gland hyperactivity" would be for crying. Most of the physical symptoms are anxiety equivalents or components of the physiological components of this affect. Thus, "nervousness," i.e., jumpiness and irritability, occurred in 39 patients (26 per cent), palpitations in 108 cases (72 per cent), hyperhidrosis in 25 cases (15 per cent), and hyperventilation in 19 cases (12 per cent). Another 28 cases (18 per cent) had two or more of various other sympathetic nervous system "overactivities."

Parasympathetic symptoms are also extremely common and occur more often in the same patient group who also tend to show sympathetic overactivity. Symptoms of peptic ulcerlike gastric overactivity and peptic ulcer itself are very common—55 cases (37 per cent), with 10 cases (7 per cent) of peptic ulcer. The observations of Mirsky (1958) appear to be pertinent here about the role of chronic anxiety in the production of peptic ulcer. On the other hand, one wonders

if there has not been a physiological change (and perhaps selection of certain physiological types) of individuals with a chronic mild alarm reaction state. We feel that the chronic exhaustion state or, as a European colleague calls it, "chronic progressive asthenia," has some endocrine and/or allergic aspects.

DISCUSSION

Attempts to fit concentration-camp survivors into pre-existing nosological categories have been on the whole unsuccessful (Bensheim, 1960; Strauss, 1961). Nonetheless, the temptation to categorize applicants for pension is apparent, and the temptation to render authoritarian decision especially great. Thus, the influence of Kraepelinian psychiatry has led to many erroneous notions and fallacious testimony in forensic psychiatry. The concentration-camp survivors developed their symptoms under unprecedented circumstances, and any pre-existing formulation or one which ignores this fact must be in error. Their symptomatology may be based on entirely different dynamics than the identical clinical pictures in other people not so traumatized. For instance, hypochondriasis in concentration-camp survivors is practically universal. But, as we have reported in detail in the past, this hypochondriasis has a specific relationship to the concentration-camp experience; namely, the hypercathexis of the body image produced by the dependence upon the body's function and appearance in order to avoid selection for the gas chamber.

The emergence and persistence of these symptoms in a "survivor" has neither the dynamic nor prognostic inference we attribute to prepsychotic hypochondriasis. Exceptional circumstances have been known to produce such symptoms. For example, hypochondriasis has been described in individuals under other stresses or trauma, even temporary voluntary emigration (Polk, 1962). Acute paranoid reactions were reported in linguistically isolated individuals as far back as World War I (Allers, 1920; Schneider, 1935b).

An attempt by Strauss (1961) to categorize his observations of 1,000 cases resulted in the highly questionable assumption that the survivors of Nazi persecution had a lower rate of all mental illness than the native population of New York, with the single exception of a slightly higher rate of hysteria. Since obsolete notions such as

that hysteria is essentially a fraud designed to get a pension (Hoche, 1929) are still prevalent in certain parts of Europe, we are confronted with the illogical conclusion that people's mental health is improved by persecution. When such studies are reviewed, and especially when the case reports by the authors of these studies are seen—as they have often been by us—it becomes apparent that behind the need to pigeonhole the survivors in neat diagnostic categories there is a defensive attitude on the part of the examiner. Some examiners appear to act like the proverbial rich man who was so “soft hearted” that he ordered his servants to keep beggars out of his sight because he could not stand the sight of their poverty and misery.

Probably the most unreliable way (and certainly the objectively most distressing way for the unfortunate victims) of psychiatric examination is to submit them to a sort of rigid question and answer method, in the style of a Prussian noncommissioned officer: the doctor asks questions and the victim furnishes replies. Sometimes these questions are even spoken in a harsh commanding tone of voice, in staccato style and military tone, which reminds the survivor precisely of the tone and manner of Gestapo men. The results of such interviews are misleading as to diagnosis and disastrous as to outcome for the victim.

Even the hearing of the tales of the concentration-camp survivors is so disturbing and traumatic, so abusive to the reaction-formations of the examiner that some are compelled to avoid obtaining the details of the traumatization. They then arrive at a meaninglessly brief summary of the experiences. Lifton's (1963) concept of psychological closure on the part of the examining or appraising physician appears to be pertinent in this connection.

Another defensive measure on the part of examiners, notable in the otherwise excellent work of our Scandinavian colleagues, is to concentrate on organic, preferably neurological changes, sometimes almost completely ignoring the disturbing history of the patients. The patients themselves are very willing to cooperate in the conspiracy of silence, as they experience the recollection as painful and often as shameful and humiliating. For instance, in the first three years of one of the author's work as examiner (Krystal), no cases of rape were reported. Becoming aware of the conspicuous absence of such histories, a special inquiry was directed to all women about it. This produced, in one year, five stories of rape, one case in which

rape was followed by continued cohabitation with a Nazi Secret Police Officer, and two more cases of "suspected" rape.

Although the group is too small for statistical reliability, these women were quite uniformly among the sickest in the group. All eight of the patients were unable to perform adequately as wives, housekeepers, or mothers. Their object relationships were ambivalent, and masochism most prevalent. They were all frigid, insomniac, and suffered from nightmares, headaches, and all the psychosomatic disturbances listed previously. The incidence of all the above symptoms was significantly higher than the total group's ($\chi^2 = 174.70$; $f = 20$, reliable at the .001 level).

A small number of patients admitted to homosexual experiences in concentration camps, although we know that Nazi officers and some Capos engaged in homosexual relations with prisoners quite freely, especially in the juvenile group.² In general, patients do not volunteer information about any sexual assaults and often deny it when the circumstantial evidence suggests it. One of the cases of suspected rape referred to above was that of a married woman taken to the Gestapo headquarters in Budapest and there assaulted to the point of unconsciousness. She denied having been raped. After her liberation, she developed severe vaginismus, which led to the break-up of her marriage. At the time of her interview several years after her divorce, she had no intention to remarry—out of disgust for sexual relationships.

The disturbing nature of the patients' histories causes both the examiners and the patients to try to avoid their pain of describing or rekindling the unheard-of cruelties committed during the Nazi era, by a sort of mutual, if unspoken or even unconscious, "conspiracy" of silence.

Rosenman (1956) has demonstrated by a psychological study of the history of natural disasters, such as plague, earthquake, or fire, that the survivors show great evidence of guilt and are moved to expiation and appeasement of God by acts such as erecting churches.³

² Persistent inquiry and high index of suspicion led to the finding of proportionately more cases of homosexual abuse since that time by Krystal. None of those were practicing homosexuals; all were married and had children, but showed a variety of compensatory reactions and depression. A couple, when examined, verged on homosexual panic.

³ Niederland has also pointed out that fantasies of rebirth, discovery of "virgin springs" and other allusions to water are also common in such circumstances.

A generalization might be made here that mankind tends to sanctify and adore martyrs but condemns, suspects, or at least ignores survivors.

Survivors of disasters and persecutions are suspected of unfair play, collaboration with the enemy, or harlotry. On a deeper psychological level, there is a fear of survivors akin to the fear of a returning ghost. Thus, Freud's (1913b) formulation of the fear of the ghost of deceased leaders, warriors, etc. being the hostile aspect of the ambivalent relationship to such figures becomes apparent by this reaction. We tend to blame the survivor for the guilt of the perpetrator. Because of the survivor guilt, the patients becomes willing partners in this conspiracy of silence, in the service of preventing their owning up to the mental material imposed by their story.

This point brings us back to a reconsideration of the two basic pathogenic forces in survivors of Nazi persecution, especially survivors of concentration camps: (1) survivor guilt; and (2) problems of aggression.

Survivor guilt, associated with the dread of aggressive thoughts and wishes, represents a nodal pathogenic factor in these individuals. Evidence of survivor guilt as a major pathogenic force was found in 92 per cent of all cases studied here. This oppressive guilt is behind many depressive and anxiety reactions of our patients. It may necessitate projection and denial of psychotic proportions.

Survivor guilt is a form of pathological mourning in which the survivor is stuck in a magnification of the guilt which is present in every bereaved person. The ambivalence, or more precisely, the repressed aggression toward the lost object prevents the completion of the work of mourning (Freud, 1917). Hidden in the self-reproach of many younger patients is their repressed rage against the now murdered parents who failed to protect them from the persecutions to which the survivors were subjected.

Closely connected to the persistence of survivor guilt and pathological mourning is the unconscious identification with the aggressor on the part of the survivors. We feel that some unconscious identification with the aggressor may have been indispensable to survival. The violent, often sudden destruction of the survivor's whole world makes the acknowledgement and working through of such identifications most threatening. To own up to death wishes in regard to a whole destroyed civilization is more than most people can do. Neither

can the therapist assure the patient that his wishes did not have magic powers, since the most fantastically destructive genocide of history did, in fact, become part of their lives. Thus, the survivor finds himself in an insoluble conflict. The only workable, but unsatisfactory, solution is afforded by repression, an ego split in which the identification with the aggressor was repressed and walled off by countercathexis. Since, in view of the magnitude of the trauma, the repression mechanism seems to have failed in a certain number of cases, as we stated earlier, the conscious awareness of such identification with the aggressor may add to the enormous burden of unconscious guilt and drive the victim into further self-isolation, brooding withdrawal, self-contempt and self-exclusion from human society, or in the case of total denial and projection, into psychotic illness.

The repressed aggressive impulses reactive to the persecution made impossible the normal evolvment, maturation, mastery, and acceptance of death-wish derivatives. In view of the wholesale destruction, it became too threatening to discover one's own destructive urges, because of the dread of their omnipotent power.

Thus, much of the symptomatology of the survivor can be traced to the maladaptive handling of the aggression by: (1) turning it against the self; (2) projection; or (3) somatization. This is the reason why the survivor's nightmares now involve his children; why his attempts to ward off aggression by obsessive-compulsive mechanisms fail; and he has to *look* at his objects to be sure that he has not hurt them.

The fate of aggression was especially carefully described by Dr. E. Sterba (1949, and this volume) who, working with adolescent concentration-camp survivors immediately after their immigration to Detroit, found that as soon as they felt safe with their foster parents they turned their aggression against them "indiscriminately."

The nature and extent of the pressure of aggression was so threatening as to necessitate resorting to desperate measures, such as "schizophrenic" defenses against aggression by the phantasy of fusion with the object. Such extreme defenses have produced a wide spectrum of clinical pictures, including those of a borderline and psychotic nature. Some patients have periods of psychotic depressions and may show schizophreniclike symptoms. Even the patients with egos capable of reality testing show evidence of regressive attitudes, especially magical thinking in regard to aggressive impulses. At

times, the pressure of aggressive impulses and defenses against them, as well as their breakthrough, can be observed to contribute to the various disturbances of cognition. In turn, when cognition is regressed, aggression is more threatening and projection facilitated. Thus, we often observe in "normally" functioning survivors, ideas of reference and mild daytime persecutory anxieties. Paranoid attitudes such as evasiveness and suspiciousness were observable in one-third of all the patients in this group.

Both the problems of guilt and aggression are probably implicated in the typical survivor nightmares. This unusual disturbance in dreams and daydream function cannot be completely explained theoretically. We are dealing, however, with a situation in which the original perception of the events was traumatic, and took place in partial suspension of ego function, in a state of depersonalization, denial, or automatization comparable to the way schizophrenic patients relate experiences they perceived during a catatonic stupor, after they recover. We may be dealing here with a disturbance of cognition and consciousness never before observed in such a large group.

Summary

The problems of survivors of massive destructive assault are many and complex. In previous chapters we have dealt with the residual social pathology. We found that the social nature of the assault upon a group or nation results in a crippling of the later attempts at restitution of families and communities. This type of pathology is passed on to future generations.

We also described a variety of disturbances of personality structures which can be directly traced to the oppressive measures. The identification with the image attributed to the victims, e.g., the "devil identity," may become a life-long burden to the survivors. At times, a reversal and reprojection may take place as in the "white devils" theory of the American Negro Muslims. More commonly, however, the victim assumes a "slave" identification or a slave "house-boy" identification. The former involves a constriction of one's human capabilities; the latter a favored position with the master (albeit ambivalent) and a turning against one's fellow sufferers.

Masochistic and paranoid attitudes are common ways of dealing with the reactive aggression. In the attempt to repress the aggressive

needs, especially in relationship to one's love objects, families become affect-lame and assume the "stalemate" relationship. The repression of aggression tends to produce problems of aggression in the next generation. The impairment in the ability for nurturing of the children tends to produce depressions in the next generation. Both problems tend to promote symbiotic relationship and interfere with the individuation of the youngster.

The survivor's faith in God is often disturbed, replaced with obsessive doubts or cursing or attempts to repair one's relationship to the divinity by the multiplication of rituals and expiatory acts. Similarly, the survivor guilt in relationship to the missing dead and their graves creates a compulsion for building memorials. However, the irreparable loss is that of faith and trust in one's fellow man and in the essentially benign nature of the world. The disturbance here is so profound that the benign introjects become unavailable as patterns for mothering and nurturing behavior. Instead, very tiring conscious efforts have to be made to ward off aggression. Despite it, aggression breaks through in dreams in which the survivor's children are subject to persecution. Hostility also breaks out in aggressive acts followed by remorse and overindulgence, which result in great inconsistency toward the children.

This problem introduces the entire dimension of social pathology. The survivors form abnormal families and communities. The families tend to be sadomasochistic and affect-lame. The communities are laden with the burden of guilt and shame, and preoccupied with the past. The imprinting of inferior status can be perpetuated by a number of generations, as illustrated by the American Negro with the much criticized "Uncle Tom" personality. On the other hand, in modern Israel, there is a necessity to dissociate even the survivors with the ghetto past and mentality, and revive more aggressive and self-respecting images from the past.

As far as the psychosomatic problems were concerned, there is a multiplicity of syndromes and causes. They all overlap with the direct physical aftereffects of the persecutions like starvation; unfortunately their nature is not precisely understood. For instance, we know neither the incidence nor the severity of liver damage produced by chronic starvation in concentration camps and ghettos. Our impression is that the incidence of liver damage is higher than is generally assumed. We do not feel qualified to discuss the many

and varied physical aftereffects of the persecutions: the typhus and typhoid epidemics and various other aspects of physical injuries, beatings, etc.

To illustrate the complexity of some of these somatic problems let us consider the problem of tiredness; there are a number of possible causes: the chronic tension, the depressive tendencies, insomnia, the possible liver disease, perhaps a psychological or physiological "break in vitality," based on a change in enzyme systems. The symptoms of tiredness occurs in people who seem to have a much lower capacity for exercise and stress. There is a progression of symptoms upon tiredness—heart pounding and sweating, and if the patients do not stop and rest at this point, they get nauseous, are likely to vomit, and suffer from headaches. This process is cumulative, because when they become too tired they cannot fall asleep, as a result of which exhaustion states may build up over the weeks without the patient being conscious of the nature of his condition.

Among the causes of insomnia, a frequent problem in survivors, are the side effects of the chronic tension states. The patients suffer from joint and muscle aches which make it difficult for them to fall asleep. They often have backaches, headaches, and joint pains with or without demonstrable evidence of arthritis or rheumatic involvement. In helping the patients to sleep, a prime concern must be the relief of pain, even though the pain is sometimes subliminal; it is experienced only as "tiredness" or soreness. Nonnarcotic analgesics are often helpful in this respect.

On the other hand, the sleep disturbances have other aspects as well. Many of these patients, despite their efforts at "trying to fall asleep," are really afraid to fall asleep, for at least two and possibly more reasons. One is that they are afraid that they will die—they have a constant fear of death. The other is that they are afraid of their dreams. Many of these patients use barbiturates to prevent themselves from dreaming. If the dreams "break through," the patients may start taking more and more of the drugs. When they are withdrawn from the hypnotics, the patients go through a period of panic, anxiety reactions, and sometimes depression.

The study of various groups traumatized in a massive manner permits an opportunity to understand social and individual pathology and its causation. The implications and uses of this knowledge stagger the imagination. We find, for instance, that the study of

populations socially isolated in camps and ghettos has direct implications upon our understanding of the effects of long-term hospitalization in chronic hospitals, mental or otherwise, of incarceration in jails and training schools, of regimentation in institutions such as the armed forces. We have reason to believe that our observations apply to victims of natural disaster. In the end, we hope that the knowledge gathered will be useful in the treatment and prevention of massive traumatization in general.

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